STATE TITLE V BLOCK GRANT NARRATIVE
STATE: TN
APPLICATION YEAR: 2006

I. GENERAL REQUIREMENTS

A. LETTER OF TRANSMITTAL

The Letter of Transmittal is to be provided as an attachment to this section.

B. FACE SHEET

A hard copy of the Face Sheet (from Form SF424) is to be sent directly to the Maternal and Child Health Bureau.

C. ASSURANCES AND CERTIFICATIONS

Assurances and Certifications may be obtained from the Tennessee Department of Health, Maternal and Child Health Section, located at 425 5th Avenue, North, 5th Floor, Cordell Hull Building, Nashville, TN 37247.

D. TABLE OF CONTENTS

This report follows the outline of the Table of Contents provided in the "GUIDANCE AND FORMS FOR THE TITLE V APPLICATION/ANNUAL REPORT," OMB NO: 0915-0172; published June, 2003; expires May 31, 2006.

E. PUBLIC INPUT

MCH continued its history of holding public meetings in concert with the WIC program regarding its role and services offered at the county level. A letter and fact sheet about both programs were sent to over 500 agencies and health care providers, and all physician members of the Tennessee Medical Association and the Tennessee Hospital Association announcing the location and time of the public hearings. Three public hearings were held across the state in May and June 2005 in conjunction with the WIC program staff. The information was released to the press, and the information was placed on the Department's web site. Any findings will be addressed.

In addition, each Regional Health Council receives a copy of the Block Grant through the regional director for review and comment. Written comments will be reviewed and included with the next Block Grant submittal.

II. NEEDS ASSESSMENT

In application year 2006, the Needs Assessment must be provided as an attachment to this section.

III. STATE OVERVIEW

A. OVERVIEW

While Tennessee has enjoyed some favorable economic trends in the past, April 2005 data show a 5.6% non-seasonally adjusted unemployment rate statewide as compared to 4.9% nationally. This trend is an increase over 2004 data for the state (4.8%). The state has a diverse market economy, a fairly large population of skilled laborers, low state taxes, and no personal income tax which attract business and industry, but this has been superimposed on a background of dwindling federal aid, transferance of jobs out of the country, and loss of manufacturing jobs and business revenue, and increasing local taxes. The State has been continually challenged with balancing its budget. Inner-city urban areas, small rural areas and unique areas such as those in the Appalachian Mountains have experienced increasing poverty.

Geography: Tennessee is a diverse state which covers 41,220 square miles of land area and is approximately 500 miles from east to west and 110 miles from north to south. The state is divided into 95 counties, each with a health department mandated by state law and located in the county seat. For departmental administrative purposes, the counties are grouped into seven rural and six metropolitan health regions.

Topographically, as well as culturally and economically, the state is divided into three grand regions. East Tennessee is a 35 county area, containing the Appalachian Mountains and bordered by Virginia, Kentucky, North Carolina, and Georgia. This region contains Knoxville and Chattanooga, the third and fourth largest cities, respectively. Johnson City, with a population over 50,000, is located in the extreme upper East end of the region and is the location of East Tennessee State University (ETSU) and the Quillen-Dishner School of Medicine. The ETSU Genetic Center provides on-going treatment and patient education after cases are confirmed by the Genetic Metabolic Centers. Erlanger Hospital in Chattanooga provides similar services after cases are confirmed. The University of Tennessee-Knoxville School of Medicine is one of the state's three Genetic Metabolic Centers, providing confirmatory diagnosis for suspected cases in the larger genetic region and treatment for those cases in the specific geographic area. These same medical sites also serve as the regional perinatal center sites. This region is home to ten nursing schools to help address the critical nursing shortage that faces our nation and public health infrastructure.

Middle Tennessee encompasses 39 counties and is bordered by Kentucky and Alabama. The topography ranges from mountains in the east to the Tennessee River on the western edge. Nashville, the capital and second largest city, and two other cities with populations over 50,000 are located in this region: Clarksville, home to the Fort Campbell military base; and Murfreesboro, one of the fastest growing cities in the state and home of Middle Tennessee State University. This region houses two of the country's oldest and most prestigious medical schools, Meharry Medical School and Vanderbilt School of Medicine; both provide program services. Meharry confirms all diagnoses of sickle cell anemia for suspected cases in the state and serves as the Middle Tennessee Regional Sickle Cell Center. Vanderbilt serves as the regional perinatal center and as another of the three Genetic Metabolic Centers confirming diagnoses for the larger region and providing treatment for cases in their specific catchment area. In addition, Vanderbilt houses one of the nation's noted Schools of Nursing which assists in developing the latest nursing curricula and produces top community program models. In addition, the middle region houses eleven more schools of nursing which assist in replenishing the retiring public health nursing infrastructure.

The western part of the state has 21 counties and is bordered by the Mississippi and Tennessee Rivers and the states of Mississippi, Missouri, Kentucky and Arkansas. This area is part of the Delta, or Gulf Coastal Plain, and is very flat, rural and sparsely populated, with the exception of Memphis, the state's largest city, and Jackson. The University of Tennessee/Memphis Medical School is the third Genetic Metabolic Center confirming diagnoses for the West Tennessee area and providing treatment for cases in its catchment area through the Boling Center for Developmental Disabilities -- an affiliate of the Medical School's Pediatric Department. This site also serves as the perinatal center for the western part of the state. Western Tennessee has ten nursing schools to address the growing

infrastructure need.

Population Changes: Using the latest federal census figures, Tennessee's 2000 population was 5,689,283, ranking the state 16th in the nation in total population. During the 1990-95 period, Tennessee's population growth surpassed the increase experienced during the entire decade of the 1980's and outpaced the national average growth rate. During the 1990-99 period, Tennessee was the fourth fastest growing state in the Southeast. Federal census updates for 2004 show that Tennessee has a population of 5,900,962, a substantial growth since the 2000 census. The distribution of Tennessee's population by race and sex has not changed significantly in the past several years: For people reporting only one race, 15 percent were black, 82 percent were white, 1 percent was Asian, and 1 percent was of other races. Tennessee's population is 48.7 percent male and 51.3 percent female, with 8 percent minority males and 9.3 percent minority females.

Tennessee is expected to gain 97,000 people through international migration between 1995 and 2025 and is expected to gain 845,000 people through internal migration for the same time period. The population over age 18 is expected to grow from 3.9 million to 5.2 million in 2025 while those classified as youth (under 20 years old) will decline from 27.7% in 1995 to 23.8% in 2025. The elderly population is expected to accelerate rapidly. All ethnic and racial groups are expected to increase during this time period except for non-Hispanic whites. African Americans, Asians, and persons of Hispanic origin will experience the greatest gain.

In 2000, 25 percent of Tennesseans were under the age of eighteen. Females aged 10-44 make up 25.4 percent of the total population. This reproductive age female population peaks within the 35-44 age group. The two largest population groups are reproductive age women and children under 18, the target population served by MCH. This has implications for outreach and recruitment efforts as well as for types of services offered.

Continuing the trend established in the mid-1980s, Middle Tennessee counties led the state's recent growth, with an average increase of 16.5% between 1990 and 1998. East Tennessee counties were next, with 6.9% growth, followed by the West Tennessee counties, which experienced a 5% net increase. Metropolitan counties (defined as those within a Metropolitan Statistical Area [MSA]) grew an average of 11.5% between 1990 and 1998.

Slightly more than a quarter of all Tennesseans live in the four largest cities. Just over 68% of Tennessee's population resides in the state's seven MSAs, five of which are in the eastern two-thirds of the state. The most sparsely populated counties are primarily in rural Middle and West Tennessee.

Ethnicity: Less than three percent of the people living in Tennessee in 2000 were foreign born, although the state has experienced a 169 percent increase from 1990. Of the foreign-born population, approximately 40 percent are of Latin American origin, and almost a third are of Asian origin. Hispanics are the largest ethnic minority in Tennessee. According to the 2003 American Community Survey, 135,669 persons, or 2.38 percent of all Tennesseans, identified themselves as being of Hispanic origin. The Hispanic population is most likely larger than the reported number due to the growing population of migrant workers and undocumented residents across the state. Middle Tennessee has slightly less than half of Tennessee's total Hispanic popuation, Memphis/Shelby County has 18.9%, and the lowest percentage (0.9) is in the upper northeast part of the state.

Tennessee has a wide variety of ethnic groups in addition to Hispanics. Southeast Asians are the second largest group (63,275), and the state is the fifth largest Kurdish community in the country. Refugees and legal immigrants have also been arriving from African, Baltic, Central Asian, and Southeast Asian countries. Among people at least five years old living in Tennessee in 2000, 5 percent spoke a language other than English at home. Of those, 51 percent spoke Spanish and 49 percent spoke some other language; 40 percent reported that they did not speak English "very well." According to the Tennessee Foreign Language Institute, there are over 140 different languages currently being spoken in Tennessee.

Tennessee's immigrant and refugee population is concentrated in the Nashville area (50-60%), in Memphis (30%) and in the rural agricultural-based counties in the southeastern and western parts of the state.

These new arrivals face access to care issues; obtaining health insurance is a critical barrier to care. In addition, they may have chronic, difficult to treat health problems that are unfamiliar to health care providers. The language barrier is a very real obstacle to care, as is the mix of cultures with which providers are equally unfamiliar. The cultural factor has a special impact on maternal and child health service delivery. In addition, in the 2005 legislative session there were several pieces of legislation which threatened to cut some of the basic services offered by any State agency for this growing population. These trends make it imperative for the Department to consider the health issues and implications of caring for this growing population.

Addressing the health needs of the state's growing Hispanic population has focused on the expansion of prenatal care services with culturally competent providers within local health department clinics, as well as expanding the availability of on-site interpreters and translated materials. The Department contracts with Open Communications International for over-the-phone translation services (mainly for languages other than Spanish) for all rural county health department clinics. The Department also contracts with the Tennessee Foreign Language Institute for translation services of written materials and interpreter assessment. MCH staff at the central, regional, and local levels are involved in developing programs and services for these new populations.

Poverty Level: Tennessee figures from the 2002 American Community Survey Profile (U.S. Census Bureau) show fourteen percent of Tennesseans live in poverty compared to 12.5 percent nationally. 18.7 percent of Tennesseans under age 18 live in poverty compared to 17.6 percent nationally. Eleven percent of all families and 32.8 percent of families with a female head of household and no husband present had incomes below the poverty level. Ten percent of the population in Tennessee received food stamp benefits within the past 12 months compared to 6.7% nationally.

According to the 2004 Kids Count Data Book, in 2001 (2000 data), 18 percent of Tennessee's children under 18 were in poverty, compared to 16 percent for the United States. Tennessee ranked 34th in the nation on this measure, up from 40th in 1996. Ten percent of children were in extreme poverty (below 50% poverty), compared to 7 percent for the nation. Seven percent of children were without health insurance, compared to 12 percent nationally. While overall poverty rates in the state and in the South have been falling, the condition of Tennessee's children is still a major cause for concern.

Income: Tennessee's median household income in 2003 was $38,247, which is 8.4% below that of the U.S. ($43,564). Tennessee's annual average rate has been below the national average since 1989 indicating that while most Tennesseans are employed, salaried and hourly employees make less on average than persons in other states. The 2003 national average per capita income was $30,527; Tennessee's for the same year was $26,808. Tennessee ranks 36th in the U.S. on this measure (University of Tennessee, Center for Business and Economic Research).

Households and Families: Of the total Tennessee households in 2002, 68% were families and 30.8 percent had children under age 18. Thirteen percent were headed by single women. The new measure of grandparents as caregivers showed 113,247 (up from 61,000 in 2000) as having responsibility for their grandchildren under the age of 18. As in most other states, about half of the grandparents who live with their grandchildren are responsible for them. Of these grandparents, 24 percent live in poverty.

Health Statistics Data: As in the nation and in the other southeastern states, Tennessee rates for adolescent pregnancy have been on the decline. In 2003-04, Tennessee mirrored the nation by showing a slight rise in infant mortality. Memphis, located in the West Tennessee region was recently noted to have the worst infant mortality rate in the nation. Low birthweight (LBW), which is a major risk factor for adverse health outcomes for both infants and children, increased in recent years and was

9.4 in 2003. In 1980, LBW was 8.0 percent; in 2000 - 2002, LBW was 9.2 percent. Additionally, the African American low birthweight rate for 2003 was 1.86 times greater than the white LBW rate. This gap has been evident for many years and continues despite the increasing availability of services targeted to these populations. Another major concern is the disparity in the pregnancy outcomes for the African American and white populations. In 2003, the infant mortality rate for births to African American women in Tennessee was 2.57 times greater than the rate for births to white women. Data for 2003 for adolescent pregnancy (ages 10-17) show the lowest rate recorded since 1975. In 2003, the adolescent pregnancy rate for this age group was 13.9. The rate dropped for both the white and the African American populations; however, the gap between the two groups remains. For 2003, the rate for the African American population was 2.4 times that for the white population. These data show that the MCH programs and services in Tennessee continue to be of great need and that resources must continue to be targeted to the populations in need.

Data trends on diseases: Disease trends for sexually transmitted diseases (STD) show that Tennessee has experienced a dramatic reduction in STD morbidity, with the exception of chlamydia, over the past five years. The rise in chlamydia morbidity has been due to additional screening within the family planning and STD clinics statewide. Like other STDs, syphilis is reported mostly from the large metropolitan areas. The six metropolitan counties represent approximately 42% of the State's population and reported 82% of the 363 cases of early syphilis cases in 2003. Nashville and Memphis reported 77% of the state's total cases. The 2003 data show a significant decrease in cases since 2000 (1,159 cases).

The number of gonorrhea cases has declined from a record high rate of 817/100,000 in 1976 to 146/100,000 in 2003. This rate compares to 169/100,000 in 2002. The metropolitan counties have consistently accounted for 75-85% of the state's morbidity.

In 1995, state funding was made available for chlamydia testing in STD and Family Planning clinics. As a result, 13,152 cases were reported in 1995, a 94% increase over 1994. The overall statewide screening positivity rate for chlamydia increased from 7% in 2002 to 12% in 2003. This increase can be attributed to more sensitive laboratory testing methods implemented in February 2003. As a result, 21,034 cases were reported in 2003. Of these cases, 73% occurred in females, reflecting the fact that most chlamydia tests are performed on women visiting health department STD, family planning and prenatal clinics. Black females aged 15-19 have the highest rate of infection. In 2003, 87% of chlamydia morbidity occurred among patients aged 15-29. Rural regions had positivity rates ranging from 5-11%, and the metropolitan areas ranged from 8-21%.

Targeted services to decrease syphilis continue in Nashville and Memphis. Counties with the highest overall STD rates are in the western part of the state, which has a high percentage of minority residents. The Department continues to place significant emphasis on STD screening, outreach, and treatment, including chlamydia, gonorrhea, and syphilis, with clinic services available in all counties and targeted outreach in the larger metropolitan counties.

Health Disparity: The confounding issues of race and poverty contribute to some of the more serious health problems and health status indicators in the state. The following is a summary of significant issues the Tennessee Department of Health (TDH) is addressing through local health department services and state health initiatives focused on women, infants and children.

African-American adolescents have a disproportionately higher pregnancy rate than white adolescents in all age groups - being addressed through the state's Adolescent Pregnancy Prevention Program, the Abstinence Only Education Program, general health education, family planning clinics and EPSDT screenings offered through the local health departments.

A higher number of minority women are likely to enter prenatal care after the first trimester of pregnancy - being addressed through TennCare enrollment of pregnant women, home visiting services, public-private partnerships and pregnancy testing and referral available at all local health department sites.

The infant death rate for minorities in 2003 was over two and one half times that of whites. African-American births comprise 20.49 percent of the total births, but 40 percent of all infant deaths were African-American.

Neonatal mortality rates are 3.29 times higher for African American infants than they are for white infants (13.5 vs 4.1). Local health departments are using the Help Us Grow Successfully (HUGS) home visiting program for special outreach and follow-up for high-risk pregnancies and high-risk neonates. The local health department serves as a first point of contact for TennCare enrollment under presumptive eligibility for pregnant women. The Healthy Start Home Visiting Program targets first time, high-risk mothers with a special emphasis on teens who are parents. The Perinatal Regionalization system is an established, effective statewide service designed to provide expert consultation about problem pregnancies and to transport the mother and baby to the next level hospital when necessary to improve the health services available to the mother and/or infant. The Campaign for Healthier Babies in Memphis and West Tennessee continues as a strong population based approach, targeting women with media messages and coupon incentives promoting the importance of early prenatal care.

The state's child fatality review system provides an additional data source for determination of need for action within the targeted populations. Child Fatality Review Teams (CFRT) reviewed 1,122 (97.3%) of the 1,153 fatalities of Tennessee resident children under age 18 that occurred in 2002. Department of Health team leaders provided administration and coordination of the teams. The CFRT reviewed the way children died (Manner of Death) in Tennessee and what caused the deaths (Cause of Death). The manner of death for child fatalities in 2002 was determined by the CFRT to be: natural causes, 72.3%; unintentional injury (accidental) causes, 19.1%; homicide, 3.92% (down from 4% in 2001); suicide, 2% (up from 1.96% in 2001); could not determine, 1.87%; and undetermined due to suspicious circumstances, 0.8%.

The child fatalities were divided into the following categories by cause of death: non-injury, 72.9% (same as 2001); injury-related, 24.3% (down from 2001); other cause not listed, 1.16%; and unknown, 1.6%. The greatest number of deaths due to non-injury resulted from illness (N=398) followed by prematurity (N=343), both figures slightly increased from 2001. Of the deaths where gestational age was reported, 137 (up from 125 in 2001) involved extremely premature infants (i.e., less than 23 weeks gestation), and 186 (down from 263 in 2001) involved gestations of 23 to 39 weeks. The greatest number of childhood fatalities due to injuries resulted from vehicular incidents, 48.7% of all injury-related fatalities. Firearm and suffocation/strangulation fatalities were the next most common cause of injury-related death, 16.1%. African-American children and children from races other than white were more likely to be involved in an injury-related fatality than white children.

African-American children, more than white children, are diagnosed with elevated blood lead levels. The Childhood Lead Poisoning Prevention Program has received funding from the CDC since 2001 to identify children with elevated blood lead levels and prevent childhood lead poisoning. Through extensive collaboration with public and private partners, the state has developed a program targeting areas of highest risk of childhood lead poisoning based on old housing, children in poverty, and number of low income housing units.

The Department of Health was one of the first departments established by state mandate. Services for women and children have always been a major part of local health department activity. By state law, there is a health department in every county; highly populated counties may have several health department sites. Title V has played an increasingly important, although often changing, role in providing services and funding for the county health department system, including services for children with special health care needs (CSHCN).

The local health department is an integral part of the health care delivery system. In rural and urban counties, the local health department provides many TennCare services as a means of assuring access to care for eligible citizens. The local health department has always provided information and

referral for county residents. Local health department nurses have provided screening and then enrollment for pregnant women presumptively eligible for TennCare.

In 1994, when the state's Medicaid managed care system called TennCare was implemented, the Title V role changed once again but has not diminished in importance. Direct services in all traditional areas of public health are still provided and new roles developed, especially in relation to outreach and follow up with patients enrolled in TennCare. Title V service providers are flexible and responsive to the unique needs of county residents since the managed care system is so varied across the state. Public-private partnerships emerged to assure that health care needs are met.

Following a full year of study, the Governor in 2004 proposed a comprehensive TennCare reform strategy designed to preserve full enrollment by placing reasonable limits on benefits. The plan won broad support from legislators, providers and enrollees, but public-interest lawyers thwarted it by refusing to lift legal roadblocks to reform.

As a result, the State in 2005 instead moved ahead with an alternate strategy to reduce benefits and enrollment for some adults while preserving full coverage for children and pregnant women. Even after reductions in adult enrollment to maintain fiscal balance, TennCare remains one of the most generous and comprehensive state health care plans. Moving forward, the State is pursuing a range of additional cost-containment strategies, including:

1) Requiring managed-care organizations (MCOs) to assume more financial risk in the delivery of TennCare benefits. The MCOs were relieved of financial risk in 2002 in an effort to stabilize the health care program. Restoring risk is critical to managing TennCare.
2) Increasing efforts to stamp out fraud and abuse. In 2004, Governor Bredesen launched the TennCare Office of Inspector General to investigate civil and criminal fraud and abuse within the program. Since then, the State has opened investigations and brought charges against scores of individuals and organizations attempting to defraud taxpayers.
3) Working through the courts to challenge legal constraints. "Consent decrees" placed on the program by public-interest lawyers beginning in the 1990's obligate the State to provide benefits well beyond federal requirements and, among other things, prevent the State from placing reasonable limits on the use of prescription drugs.
4) Developing new care- and disease-management practices and making better use of health information technology (HIT). For example, the Governor's Volunteer eHealth Initiative is one of five federally funded HIT demonstration projects designed to lay out a national blueprint for improving the quality of health care while reducing costs in the health care system.

The State has reached a tentative agreement with TennCare enrollee attorneys and stakeholders that would preserve health coverage for approximately 97,000 "medically needy" enrollees -- the sickest and neediest who generally do not qualify for Medicaid -- in exchange for relief from certain legal constraints related to TennCare. The proposed reform was allowed to disenroll some 226,000 individuals including: 1) persons who were dually eligible on Medicare; 2)persons who are uninsurable but are eligible to transfer coverage under federal HIPAA rules; and 3) uninsured adults who could conceivably obtain insurance elsewhere. The disenrollment started June 2005. The proposed reform will limit pharmacy benefits and medical services for those adults remaining on the program. However, it does not affect the benefits of children or pregnant women.

In an effort to help the soon to be disenrolled population, Governor Bredesen appointed a "safety net" task force to make recommendations. The Governor's Task Force on the Healthcare Safety Net, the 26-member Task Force of health care professionals, state lawmakers, cabinet officials and local representatives, delivered its final report in May 2005 outlining 16 broad recommendations for strengthening safety net options in conjunction with reforms to TennCare. The recommendations are grouped in three categories:

•Core Recommendations -- basic elements of a stronger safety net.
•Recommendations for Future Consideration -- items to consider should additional funding become

available.
•Recommendations for Future Adjustments to TennCare -- options for bolstering traditional safety net providers via the state's health plan.

Some of the items in the Task Force report already were addressed in the Administration's budget. The five "core recommendations" by the Task Force are:

1) Expand the Safety Net and Support Local Initiatives. Among other things, the Task Force recommended expanding Tennessee's network of local health departments, federally qualified health centers (FQHCs) and faith-and community-based clinics.
2) Prevent Inappropriate Use of Emergency Departments. To minimize hospital emergency room visits, the Task Force recommended establishing a 24-hour nurse hotline to provide medical consultations to more than 200,000 TennCare enrollees who may lose coverage.
3) Maximize Federal Resources. The Task Force recommended providing technical assistance to make FQHCs more competitive for federal grants; pushing for a limited increase in state matching dollars to draw down federal Ryan White funds to assist HIV patients; and leveraging federal programs to attract health professionals to underserved areas.
4) Identify Insurance Options for Disenrollees. The Task Force recommended providing funding to "bridge" pharmacy coverage for Medicare-eligible TennCare enrollees until the federal prescription-drug benefit takes effect in January and exploring incentives to encourage small employers to offer health coverage.
5) Evaluate Options for Prescription Discounts. To hold down the costs of prescription drugs for the uninsured, the Task Force recommended exploring a state-sponsored drug discount program that would leverage bulk buying power in order to negotiate lower prices.

In addition to the core recommendations, the Task Force report outlines nearly a dozen suggestions including: establishing regional referral networks to ensure patients can access safety net services; recruiting active and retired health care professionals to donate time in clinics and other facilities; and increasing rates for TennCare providers that will continue providing critical services to the disenrolled. The report also calls for ongoing review and evaluation of the status of the health care safety net.

In April 2004, The Commissioner for the Department of Health announced his initiative aimed at giving babies good lifestarts and adults and children good lifestyles. The goal of the Better Health: It's About Time! (BHIAT)initiative is to raise public awareness about the importance of a healthy lifestyle, to encourage individuals to take personal responsibility for their health and well-being, and to give newborn babies a better start in life. BHIAT initiative specifically targets cardiovascular disease, obesity, diabetes, infant mortality, prenatal care, and adolescent pregnancy, and also aims to eliminate racial and ethnic health disparities in these areas.

Heart disease and stroke continue to be leading causes of death in Tennessee. Tennesseans also report a high prevalence of diabetes. In 2002, these three diseases resulted in premature deaths that translate to 61,540 years of potential life lost for Tennesseans. A contributing factor to these diseases is obesity, and Tennessee ranks 8th worst in the nation for the percentage of adults who are obese. According to the results of the 2002 Behavioral Risk Factor Surveillance Survey and data collected by the Department of Health, an estimated 34 percent of adults in Tennessee do not exercise at all. Six out of ten adults reported being either overweight or obese. Tennessee has the 4th highest smoking rate in the nation, with approximately 28 percent of adults being smokers. Seven out of ten people do not eat the recommended amount of fruits and vegetables. In 2002, more than 13,000 babies were born in Tennessee to mothers who smoked. Prenatal care was inadequate in 11.2 percent of live births in Tennessee in 2002. Tennessee's infant mortality rate was almost 50 percent higher compared to the U.S. rate. Only five states had a higher percentage of low-birthweight babies. While adolescent pregnancy rates have declined over the last few years, Tennessee's rate still exceeds the overall rate of the United States. Racial and ethnic minorities have experienced a disproportionate burden of low-birthweight births and infant deaths, as well as death and disease from chronic illnesses--at rates that are two to three times higher in some cases.

The Commissioner went on record to say that the Department of Health will be working diligently on a number of efforts to address these problems, utilizing intradepartmental strategies to focus existing resources and programs on the targeted issues, as well as intragovernmental strategies to collaborate with other departments. The Department is also working to form partnerships with non-governmental agencies, community-based organizations and the faith community.

The local health departments have a positive reputation for helping people, and there is little stigma attached to seeking this service. From 1998- 2003, local health departments assisted TennCare by re-verifying eligibility for those enrolled, a Health Care Finance Administration (HCFA) requirement for the Medicaid waiver. All these activities are in keeping with the departmental policy, articulated by the Commissioner, that local health departments should be the focal point for service for any human service need.

B. AGENCY CAPACITY

The state has local health departments in all 95 counties that carry out health related programs for women, infants and children. Local health departments operate in collaboration with the county executive or mayor and county commissioners. Metropolitan counties have boards of health which set general policy for their health departments. Funding for local and metropolitan health departments comes from local, state and federal government sources, third party payers and client fees. Maternal and Child Health funds contribute to the financial base of all county health departments.

Each county has one or more health department sites delivering health services, including family planning, child health, EPSDT, immunizations, home visiting services, care coordination for families with children with special health care needs, pregnancy testing, basic prenatal care, prevention and treatment of sexually transmitted diseases, WIC, and TennCare outreach and advocacy. Other services (primary care, prenatal care, tuberculosis and HIV/AIDS management, etc.) are provided at selected sites depending upon need and availability of resources. The Department (TDH) contracts with universities, hospitals and other agencies for services such as perinatal regionalization services, genetics, children's special services, additional family planning sites, abstinence only education and child care technical support services. Primary care services are provided by 11 of the 95 county health departments designated as TennCare primary care providers and provide 24-hour coverage and referral.

While certain basic health services are available at local health departments regardless of health care coverage status, others are negotiated with the managed care organizations (MCOs) based on gaps in the health care delivery system. The Department contracts with those MCOs operating in the rural counties to provide some traditional public health services without prior authorization from the MCO. Other health services can be provided to women, infants and children if individual authorization is approved. Staff are very involved in care coordination and case management to assure that women, infants and children enrolled in TennCare receive the services they need.

Description of Children's Special Services (CSS) Program:

Children's Special Services (CSS) is the state's Title V CYSHCN's program. Children's Special Services addresses the special health care needs of children from birth to the age of 21 years who meet both medical and financial criteria. State statue defines special health care needs children as: "Children shall be deemed chronically handicapped by any reason of physical infirmity, whether congenital or acquired, as a result of accident of disease, which requires medical, surgical, or dental treatment and rehabilitation, and is or may be totally or partially incapacitated for the receipt of a normal education or for self-support. This definition shall not include those children whose sole diagnosis is blindness or deafness; nor shall this definition include children who are diagnosed as psychotic."

Children Special Services has an established financial criterion of income not greater than 200% of

the federal poverty level. The program financial guidelines are updated by April 1st of each year. In order to assist families in qualifying financially, the CSS program will use spend-downs including; premiums paid to other health insurances, payments for child support, and any paid medical bills incurred over the past year for the entire family.

CSS provides reimbursement for medical care, supplies, pharmaceuticals, and therapies directly related to the child's diagnosis. Medical services are provided through a network of CSS and TennCare approved providers. Each family is required to apply for TennCare and assisted in finding a medical home as well as any needed specialists.

CSS conducts various multidisciplinary medical clinics in the regional offices, university hospitals, and other private provider offices. Comprehensive pediatric assessment clinics are only held in 1 of the 13 regions/metros due to primary care services being conducted through TennCare and its physician provider network. CSS holds numerous orthopedic clinics and craniofacial clinics throughout the state. Since most children have some form of health insurance, including TennCare, the program makes every effort to obtain reimbursement for medical services.

All families with children who are newly eligible for Supplemental Security Income (SSI) are contacted by CSS and provided information on CSS, mental health, mental retardation, early intervention (TEIS), genetic services and other health department services that may be available. Approximately thirty-three percent or 2,000 of the 6,100 CSS enrollees have SSI.

CSS provides care coordination services to all its clients in all 95 counties. Care coordination services are provided by social workers and public health nurses and include: assessments of both medical and non-medical needs, and serving as a liaison between the medical provider, insurance company, transportation services, and the family. CSS care coordinators may attend CSS clinics, private clinics, and multidisciplinary meetings in the educational setting.

Children's Special Services recognizes the need for parents of a recently diagnosed child to talk and meet with other parents of a similar or like diagnosis child, so those parents can impart their knowledge, understanding and experience. If a family cannot be referred to another parent of a similar or like diagnosis then the family is referred to the national Mothers Understanding Mothers (MUMS) organization. At present, CSS does not reimburse the $5.00 fee for using the MUMS service. The CSS program is continuing to attempt to contract the Parents Encouraging Parents (PEP) portion of the program to the private sector. The challenge has been locating a qualified agency capable of delivering services in all 95 counties.

Project TEACH (Together Educating and Coordinating Health) provides coordination of services for CYSHCN in the school system as well as assisting the schools in processing payments from third party insurance companies, including TennCare. The program is staffed by nurses and social workers who coordinate efforts in 45 of Tennessee's 139 school systems. Over the past few years, millions of dollars have been saved by the school systems by accessing other payment sources, but more importantly children have been identified as needing services that would not have received needed care.

Description of preventive and primary care services for pregnant women, mothers and infants:

All local health departments provide pregnancy testing, counseling, and referral for prenatal care; HIV testing and counseling; WIC and nutrition services; presumptive eligibility for pregnant women for TennCare/Medicaid (pregnant women below 185% of the federal poverty level are eligible for TennCare); and testing for sexually transmitted diseases. Staff assist with referrals to the Department of Human Services, which is responsible for TennCare enrollment. Staff also provide outreach and advocacy services for TennCare enrollees, including assistance in accessing medical care by identifying providers and setting up appointments, reminder phone calls, assisting the enrollee in understanding the TennCare system, assisting with appeals, and educating enrollees about the important concepts of a medical home, use of the primary care provider, and preventive health

education. All regions have home visiting services for pregnant women and infants considered to be at risk and in need of such services.

The state's perinatal regionalization system consists of the five regional perinatal centers, making high-risk obstetrical and neonatal care accessible to all physicians and health care facilities statewide. This system provides a mechanism for consultation regarding high-risk pregnant women and infants and a system of referral and transfer, when necessary. The system also provides postgraduate education in perinatal medicine for health care providers. Access to the appropriate level of high-risk care is facilitated through the agreements among delivering hospitals, physicians and the centers. The perinatal regionalization system has a 21-member Perinatal Advisory Committee staffed by Women's Health. During FY 2004, there were 13,413 deliveries at the five Regional Perinatal Centers, 4,235 NICU admissions, 1,186 newborn transports, 961 follow-up clinic visits, and 5,855 educational hours provided to health care providers. Staff at the Centers provided approximately 2,418 documented telephone consultations and 22,586 onsite patient consultations.

Family planning services are available in every county at 131 clinic sites (health departments, Planned Parenthood agencies, primary care sites). Services include counseling and education, exams, laboratory tests, and contraceptive supplies, and are available upon request to any reproductive age person. During CY 2004, services were provided to 112,098 persons.

The Women, Infants and Children (WIC) Program provides supplemental food items to approximately 154,400 eligible participants each month. Participants are pregnant, breastfeeding, and postpartum women, infants and young children under five years of age who are at risk of poor growth, who meet the required income guidelines. Services to certify participants and issue vouchers for the foods are provided at approximately 135 local health department, primary care, and hospital sites throughout the state. Nutritionists teach individuals or groups proper nutrition for everyday living. Registered dietitians counsel individuals with special dietary needs such as hypertension, diabetes and weight management. Breastfeeding classes and support are also available statewide.

The state's Genetics and Newborn Screening (NBS) Program requires by law that all babies be screened for metabolic disorders prior to discharge from the birthing hospital. The Program has established a network of tertiary level providers for referral, case management and treatment of infants and children with genetic and metabolic diseases, including sickle cell disease. The NBS follow-up nurses are located at the State Laboratory to assure that all abnormal results are reported as quickly as possible. The program involves cooperation between birthing hospitals, the State Laboratory, the NBS Program staff, the Genetic Centers, Sickle Cell Centers and primary care physicians. The state is currently testing for 34 diseases (which may reflect 50 different genetic disorders). For additional information, see NPM #1.

Newborn Hearing Screening - CY 2004 data indicated that 84 of the 89 birthing facilities provided hearing screening to 97% of the birth population. Seventy-nine facilities reported hearing screening results on the state metabolic/genetic blood spot form. Facilities are encouraged to provide screening for all newborns. Education for providers and families is provided by the Tennessee Newborn Hearing Screening Program (NHS). NHS monitors the progress of birthing facilities that provide universal newborn hearing screening. The Department has a HRSA Newborn Hearing Screening Grant and a CDC Early Hearing Detection and Intervention Tracking, Research and Integration Grant. The goal to increase the number of hospitals that provide universal hearing screening programs is ongoing. The rate of follow-up for infants referred for further hearing screening increased from 64% in CY 2003 to 82% in 2004. The increased rate was due to the follow-up services by the Tennessee Early Intervention System (TEIS) through a cooperative agreement with the Department of Education, IDEA Part C program. For additional information, see NPM #12.

Description of preventive and primary care services for children:

Child Health : The CHAD home visiting program continues to be partially funded by the Tennessee Department of Children's Services. In FY 2005, CHAD will offer services in 22 rather than 23

Tennessee counties. Sullivan County will offer all of its home visiting services through the HUGS program rather than offering both CHAD and HUGS. In FY 2004, the CHAD program served 1,025 families, which included 1,427 children. In FY 2004 the Healthy Start program served 1,416 families, which included 1,752 children.

EPSDT: All 95 county health departments continue to provide EPSDT screenings to TennCare-eligible children. In FY 2004, 63,273 screenings were done. This is an increase of 11,428 screenings for the year. As previously reported, the Department of Health assumed the responsibility of screening children in the custody of the Department of Children's Services in June 2003. Data for 2003-04 from DCS show that 98% of children had been screened. Data for Fy 2005 show that the local health department clinics provided 62,884 EPSDT screenings. The recently implemented TENNderCare Community Outreach program and the Call Center program are fully staffed and operational. This should result in raising the awareness and utilization rates of children eligible for screenings.

ECCS:Early Childhood Comprehensive Systems (ECCS) has created a diverse, statewide advisory committee that comprises a network of representatives from State departments, public and private agencies, parents, advocates, representatives of faith-based organizations, the Academy of American Pediatrics, Head Start, the Governor's Office- Children's Cabinet, United Way- Success by Six and Child Care Resource and Referral Centers. The primary objective of the network is to develop strategies to identify gaps in service and to outline long term plans for a seamless system of care that has a positive impact on school readiness of children. The ECCS advisory committee met quarterly to analyze existing needs assessment data and identified problem areas affecting the healthy growth and development of the targeted population- children birth to five years of age. Their current charge is to specifically address the five critical elements of the grant: Access to Medical Home and Insurance; Early Care and Education; Mental and Socio-Emotional Health;Parenting Education; and Family Support. Members are assigned to four workgroups based on these critical elements and the individual sub-committees continue to plan result-focused strategies by monthly phone conferences and e-mail communications. (Parenting Education and Family Support elements are combined). Working cooperatively, MCH staff who selected early childhood indicators at ECCS meetings now facilitate these workgroups by sharing their expertise in special needs, school health issue and environmental influences such as lead poisoning. On-site consultations and technical assistance is provided as needed by the analyst of Health Systems Research, Inc. of Washington, DC.

The ECCS project director/ nurse consultant is solely responsible for the coordination of the grant, planning advisory committee activities and insuring that there is a transition of the CISS grant along with continuation of the objectives of the Healthy Child Care America program. Thus, she attended the National ECCS grantees meeting held in Washington, D.C. in December of 2004 and is enrolled in the National Training Institute for Child Care Health Specialists conducted by the University of North Carolina at Chapel Hill.

Child Care Resource and Referral Centers (CCR&R): There are more than 4,900 regulated child care providers with a capacity to serve more than 330,000 children. The staff of the 11 Resource and Referral Centers include child care specialists as well as specialists in other areas related to child care. Direct services rendered to child care providers included over 3,000 training sessions, on-site consultations, and use of regional lending libraries -- most related to the prevention of health and safety problems for the children served. Indirect services included community presentations, a quarterly newsletter, and a CCR&R website linked to the Department of Health's site. Parent referrals are routed over a toll-free phone number that is promoted locally in a colorful brochure. Community participation is noted by CCR&R involvement with several advisory boards including the Early Childhood Comprehensive Systems (ECCS) and the Tennessee Association for the Education of Young Children (TAEYC).

MCH provided partial funding for the salaries of the health specialists, books, and audio-visual teaching materials for each of the lending libraries. Besides one-on-one technical assistance, this past year MCH assisted with coordinating training sessions on health and safety issues for CCR&R staff during quarterly "Train-The-Trainer" workshops. In partnership with the Department of Human

Services and Signal Centers, future training will focus on improving health and safety scores on the Star-Quality Assessment Program.

Adolescent Health: Adolescent health regional representatives were recruited and met to plan regional adolescent health trainings. Most regions have conducted this training which focused on how to provide "youth friendly" services, addressed obesity issues among adolescents and invited a local youth panel to the clinic to discuss their health perspectives.

An adolescent health data report is in the final stages of production and will be distributed to policymakers, adolescent health program staff as well as other adolescent health stakeholders. Adolescent youth health guides were distributed to approximately 100,000 young people through contacts working in schools, faith community, and youth organizations. Conference planning and underwriting was provided for the Yes2Kids Conference. Adolescent health educational materials have been ordered for each region. Adolescent health fact sheets were developed and made available via the Department's web site.

A SAMSHA youth suicide prevention grant proposal was written in partnership with the Tennessee Department of Mental Health and Developmental Disabilities. The adolescent health web site was updated. Asset building training was provided to ten Coordinated School Health Program teams. Two adolescent health e-newsletters were written and distributed to all adolescent health contacts statewide. The director of adolescent health has provided consultation and developed training materials for the EPSDT Outreach committee. Throughout the year, technical assistance information has been shared with adolescent health contacts statewide via email.

Child Fatality Review Team (CFRT)- The state's child fatality review system provides an additional data source for determination of need for action within the targeted populations. Child Fatality Review Teams (CFRT) reviewed 1,122 (97.3%) of the 1,153 fatalities of Tennessee resident children under age 18 that occurred in 2002. Department of Health team leaders provided administration and coordination of the teams. The CRFT reviewed the way children died (Manner of Death) in Tennessee and what caused the deaths (Cause of Death).

Sudden Infant Death Syndrome (SIDS) -- The SIDS program includes making autopsies available for every suspected SIDS death and providing support to parents and their families through published materials, home visits by a public health nurse, and referral for counseling and association with parent groups of those who have experienced a SIDS death. A law mandating the Departments of Health and of Children's Services to train first responders (Emergency Medical Technicians, professional firefighters, and law enforcement officers) in conducting the Death Scene Investigation of the sudden unexplained death of a child has progressed. This training entitled "Prevention Through Understanding" must include information about SIDS and responding to a grieving family. In January, a Death Scene Investigation In-service for Trainers was conducted in Memphis. The curriculum manuals and the in-service program have been approved for in-service and pre-service training by the Commission for Law Enforcement, the State Commission Board for Fire Fighters, and the Board of Licensure and Education for Emergency Medical Services. "Prevention Through Understanding" has been approved for five contact hours for trainers who go through the program and for two contact hours for trainees who attend a trainer in-service or pre-service program. To date, a total of 367 trainer manuals and 1,542 trainee manuals have been distributed.

Childhood Lead Poisoning Prevention Program (CLPPP): The Childhood Lead Prevention Program has received funding from the CDC since 2001 to identify children with elevated blood lead levels and prevent childhood lead poisoning. Through extensive collaboration with public and private partners, the state has developed a program targeting areas of highest risk of childhood lead poisoning based on old housing, children in poverty, and number of low income housing units. See State Performance Measure #2

Dental Health: Dental services are required under EPSDT guidelines that are to be followed by the MCOs. There are significant shortages of dentists in MCO networks, and some areas of the state

have no dental services available. To counteract this shortage, the Rural Health Initiative allows health regions to submit proposals through their Regional Health Councils to establish special dental, obstetric, pediatric and/or primary care services needed in their communities. Fifteen projects have been approved for funding under this new initiative. Many have chosen to develop mobile dental services targeting school children during the school year and providing services to others during holidays and summer. See NPM #9 for more information

Help Us Grow Successfully Program (HUGS):- Program goals are to reduce complications of pregnancy, subsequent unplanned pregnancies, developmental delays in children, and maternal and/or infant morbidity and mortality through home visiting services and a case management model. Services are targeted to prenatal and postpartum women up to two years after delivery (including women who have lost a child due to miscarriage, stillbirth, prematurity, SIDS or other causes) and children birth through the age of 5 years. These services assist clients in gaining access to health care (well-child checks, immunizations, EPSDT, WIC, etc.), psychosocial, educational and other necessary services to promote good health practices and improve general well-being. The program continues to expand services by working with the Child Fatality Review staff to receive referrals and provide services to women who have lost a child under age two. Services are provided to assist these women and their families cope with the grieving process and improve the outcome of future pregnancies. 22,851 visits were made in FY 2003, 32,467 in FY 2004, and it is estimated to reach more than 35,000 in FY 2005. The increase in visits may be due to the additional staff added during FY 2004. The HUGS staff consist of 175 nurses, social workers and paraprofessionals as well as 13 Program Directors to coordinate seven regional and six metropolitan sites. The program currently serves 74 of the 95 counties across the State of Tennessee. Plans are currently underway to expand the program to all 95 counties.

School Health: Several major objectives will be accomplished during the 3rd year of the Coordinated School Program. By fall of 2005, the Commissioners of the Department of Education (DOE) and the Department of Health (DOH) will have signed a Memorandum of Agreement expressing their support for Coordinated School Health (CSH) and Reduction of Chronic Disease. By February 28, 2006, DOE and DOH will revise the Lifetime Wellness Curriculum standards and the Lifetime Wellness Resource Manual for use with the 139 local education agencies (LEA). In collaboration with Middle Tennessee State University, a statewide cadre of 10 members will be established for the purpose of providing 10 training events promoting CSH and Reduction of Chronic Disease through Physical Education/Activity, Nutrition, Tobacco Use Prevention and Safety (PANTS). In additon, institutions of higher education will be contracted to conduct 5 coordinated school health and PANTS institutes for 100 educators. A statewide health conference for 400 Tennessee educators will be conducted. Mini-planning grants will be issued to LEAs to provide resources for planning and implementing a coordinated school health program including administration of the School Health Index.

Abstinence Education: Federal funds were used in FY 2005 to fund 21 community based projects in 18 counties. An annual statewide conference for parents, youth development workers, and state employees has been conducted since 1999. Technical assistance is also provided to funded projects, SPRANS and other agencies needing guidance with abstinence training. SPRANS funded agencies receive funds directly from the federal government for abstinence education. Education brochures are housed in Central Office and are distributed across the state free of charge to nonprofit agencies upon request.

Description of culturally competent care appropriate to MCH population:

Language barriers pose challenging communication issues at almost every level of the health care delivery system. The continuing increase in Spanish speaking populations has created a critical need for appropriate language services by health care providers across the state. The Department contracts with Open Communications International (OCI) to provide over-the-phone translation services (mainly for languages other than Spanish) for rural health department clinics. Assistance with over 170 different languages is available. Through a toll-free number, interpreters can be accessed 24 hours a day. OCI has provided materials to all health departments to inform non-English speaking

clients of this service and allow them to visually indicate their preferred language.

The Department also contracts with the Tennessee Foreign Language Institute for translation services of written materials and interpreter assessment. The Department has developed and implemented Title VI Policies and Procedures for limited English proficiency, which are applicable to all Health Services Administration programs that are receiving federal financial assistance. Topics covered include data collection, analysis and reporting, oral language interpretation, translation of written materials, providing notice to LEP persons, staff training, and quality management.

State statutes relevant to Title V program authority are discussed as follows:

TCA 68-12-101 to112 - The Crippled Children's Act of 1934 establishes state services for children with special health care needs who meet income and diagnostic guidelines. The Act further establishes an advisory committee and directs that certain geographic requirements be met.

TCA 68-5-401-503 - The Genetics and Newborn Screening Act establishes the statewide program responsible for screening and follow-up with all babies born who have questionable or confirmed lab results for genetic and inborn errors in metabolism.

TCA 68-142-101-109 -The Child Fatality Review Act of 1995 requires that review teams be established in each judicial district of the state and that all deaths to children under the age of 18 are reviewed. It further requires that an annual report is written and that a statewide advisory group is convened at least annually by the Commissioner to review findings and recommend policy.

TCA 71-3-151-165 - The Welfare Reform Act of 1996 requires that TDH, through the local health departments, provide home visiting services to families with young children within 30 days of termination from the program for reasons other than self-sufficiency.

TCA 37-3-703 - Establishes the Hawaii model of Healthy Start for families at risk of child abuse and neglect.

TCA 68-34-101-111 - The Family Planning Act of 1971 established the statewide family planning program, which included availability of contraceptives, eligibility for services, disposition of funds and services to minors.

Associated statutes related to maternal and child health issues are implemented by other sections of the Bureau of Health Services. The Traumatic Brain Injury Program (TCA 68-55-101-402) establishes the head and spinal cord injury information system and advisory council; TCA 68-143-101-103 establishes a statewide public awareness campaign for shaken baby syndrome addressed jointly by the Departments of Health and Human Services. Tennessee was one of the first states to legislate child safety through the required use of child safety seats (TCA 55-9-602-610), which took effect in 1977. A Child Bicycle Safety Act (TCA 55-52-101-106) was passed in 1994 requiring all operators and passengers under the age of 16 riding on a state roadway to wear approved protective bicycle helmets and defines additional requirements for other riders. State statute declares it an offense to transport a child under 6 years old in the bed of a pickup truck on any roads of any county or state highway.

Legislation from the 2005 session included: (1) allowing schools who want to participate to obtain a body mass index of all its students and send to parents with general recommendations; and (2) mandating the autopsy of any child age 17 or younger who dies under suspicious circumstances.

C. ORGANIZATIONAL STRUCTURE

The Tennessee Department of Health is a branch of state government with a commissioner appointed by the Governor. There are thirteen regions under the state health department serving the 95 counties. Seven of the regions are comprised of rural counties, and six are comprised of metropolitan

counties under the jurisdiction of metropolitan city councils/government. The counties in the seven rural regions are a part of the state's administrative system, whereas the six metropolitan counties are a part of the county administrative systems. Each county has a local health department with at least one clinic site. The central office of the Department, including Maternal and Child Health and Women's Health/Genetics, functions as the support, policy-making, and assurance office for the public health system. Central office program staff work closely with staff in both rural and metropolitan regions on all program activities. The primary difference between the two types of regions is the method used to provide funding. Rural regions are part of the state government system, and metropolitan counties are separate city/county government systems. Both operate maternal and child health programs using the same standards and guidelines. The central office provides support and technical assistance to both rural and metro regions.

The Department of Health has a range of responsibilities, including administering a variety of community health programs, licensing health care professionals and maintaining health records and statistics. The Department works closely with local governments and nonprofit agencies to monitor and improve community health. The Department is organized into four bureaus and seven support sections. The Bureaus are Alcohol and Drug Abuse Services, Health Licensure and Regulation, Health Services, and Administrative Services. The support sections include the State Laboratory, Office of Minority Health, Office of Policy, Planning, and Assessment, Office of Human Resources, Office of General Counsel, Office of Communications, and Office of Information Technology. The Maternal and Child Health Section and the Women's Health/Genetics Section are in the Bureau of Health Services with those other sections providing services across the state (Communicable and Environmental Disease Services, WIC/Nutrition Services, Community Services, General Environmental Health, HIV/STD, Medical and Dental Services, Regional and Local Health).

Maternal and child health services are within two sections of the Bureau. The MCH section consists of Child and Adolescent Health Services and Children's Special Services. Women's Health/Genetics has Genetics and Newborn Screening Services and Women's Health. Organizational charts for the Department, the Bureau of Health Services, Maternal and Child Health, including Services for Children with Special Health Care Needs, and Women's Health/Genetics are available upon request.

The administration changed with the election of Philip N. Bredesen as Tennessee's 48th Governor in November 2002. In February 2003, Governor Bredesen named Kenneth S. Robinson, M.D., to serve as the Commissioner of Health. Dr. Robinson, a physician and minister, also has served as Assistant Dean for Admissions and Student Affairs at the University of Tennessee, College of Medicine, and taught and practiced internal medicine for 10 years at Vanderbilt University. Dr. Robinson is a national authority in developing community health and wellness programs through churches and nonprofit organizations.

The Department of Health was one of the first departments established by state mandate. Services for women and children have always been a major part of local health department activity. By state law, there is a health department in every county; highly populated counties may have several health department sites. Title V has played an increasingly important, although often changing, role in providing services and funding for the county health department system, including services for children with special health care needs. The state has local health departments in all 95 counties, established by state mandate, that carry out health related programs for women, infants and children. The Department of Health is responsible for the overall administration of the Maternal and Child Health Block Grant funding and all the programs, projects, and activities which are components of maternal and child health.

Funds that support MCH section activity include several special funding sources in addition to the MCH Block Grant. The state's award for State Systems Development Initiative (SSDI) has been used to develop the computer network and data management infrastructure. This funding stream has benefited not only MCH but also the other sections of the Bureau of Health Services since SSDI funds were used to develop an integrated database on clients and services for program management called PTBMIS, which is used by all health service programs. SSDI funds have also been used to upgrade

the hardware and software used in the Genetic and Newborn Screening Program, which is under the direction of Women's Health and fulfills the state mandate to screen every baby born in the state for metabolic disorders.

The section has administered a Community Integrated Service System (CISS) -- Health in Child Care grant until spring 2005, when the grant terminates. These funds were combined with funds from the Child Care Licensing Division of the Department of Human Services and the Developmental Disabilities Council to fund Child Care Resource and Referral Centers (CCR&RC) in the Department of Human Services (DHS) regions of the state. There are currently 11 Child Care Resource and Referral Centers statewide serving approximately 5,250 regulated child care providers who provide care for 331,230 children. These centers provide technical assistance to all child care facilities in their geographic areas with the goal to improve developmentally appropriate practices; address health and safety issues in child care settings and increase inclusion of children with special needs in established child care programs. Tennessee was also successful in competing for the last year of the CISS-Child Care grants requiring training of child care health consultants who are associated with the established child care resource and referral centers. CISS grant funding is used to replicate the child care health consultant training developed by UNC -- Chapel Hill for these staff persons. Each of the CCR&RCs employs a professional who serves as a child care provider specializing in health. During 2003, 13,896 participants, not unduplicated, received 30,264 hours of training on child development, early childhood education, health and safety, developmentally appropriate behavior management and child care administration through the Tennessee Child Care Provider Training (TN-CCPT). Each licensed child care provider also receives an annual on-site visit from a CCR&RC specialist. MCH has allocated $150,000 from the Block Grant as one portion of continuation funding for the centers, to support CCR&RC positions and to focus training for the areas in state with the worse health and safety scores. CISS funding is used to support the training of CCR&RC staff.

The state's Abstinence Only Education Program is under the direction of MCH. The federal funds supporting this program are being used to support 21 projects in community based organizations in 18 counties. A statewide fall conference on the importance of abstinence until marriage and character education for school aged youth has been held annually since September 1999.

The CDC-funded Childhood Lead Poisoning Prevention Program is under the direction of MCH. Funding has been received since 2001 for providing screening, follow-up, education of providers and the general public, and surveillance/data collection in all 95 counties. Effective July 2003, a three-year cycle of funding from the CDC combined the two federally funded programs in the state into one statewide effort. For 2003, 51,595 children ages 6-72 months were screened; 199 had a confirmed blood lead level >10 ug/dl. In 2004, 49,547 children ages 6-72 months were screened; 262 had a confirmed blood lead level >10 ug/dl.

The Women's Health/Genetics Section is responsible for the Title X family planning program which provides comprehensive family planning services in all 95 counties through 131 clinics, including local health department clinics, Planned Parenthood agencies, and primary care centers. For 2004, the program served 112,098 clients, of which 83% were at or below 150% of the federal poverty level.

The Newborn Hearing Screening Program, administered by staff in Women's Health/Genetics began a fifth year of funding March 31, 2005, with Tennessee's Health Resources and Service Administration (HRSA), Universal Newborn Hearing Screening Program (UNHSP) Grant CFDA# 93.251. Completion of the goals and objectives of the grant continue to be on track. The focuses for the fourth year were to provide education for the physician and audiology communities; develop and distribute new Pediatric Audiology Assessment and Amplification Guidelines; distribute the newly developed Parent Packet with resource materials for parents and families of infants identified with hearing loss; and increase the number of infants obtaining follow-up services. The fifth year grant is focusing on the distribution of individual hospital status reports, satisfaction surveys, on-site monitoring of hospitals, and data integration with other programs.

MCH administers the Child Health and Development (CHAD) Program that is funded by the

Tennessee Department of Children's Services to provide home visiting services primarily to families of abused or neglected children (or those at risk of) in 23 counties.

MCH received an Early Childhood Comprehensive Systems (ECCS) Planning grant June 1, 2003, to create a statewide network of partners to evaluate the current systems capacity, conduct a statewide needs assessment, prioritize identified problems areas, and develop an implementation plan. Transitioning of the CISS grant and sustainability of the Early Childhood Comprehensive System are included. The Child Care Resource and Referral Center staff is an integral part of the ECCS development. The primary objective of the network is to develop strategies to identify gaps in service and to outline long term plans for a seamless system of care that has a positive impact on school readiness of children. The ECCS advisory committee met quarterly to analyze existing needs assessment data and identified problem areas affecting the healthy growth and development of the targeted population- children birth to five years of age. Members were assigned to four workgroups based on the five critical elements and the individual sub-committees continue to plan result-focused strategies by monthly phone conferences and e-mail communications. (Parenting Education and Family Support elements are combined). Working cooperatively, MCH staff who selected early childhood indicators at ECCS meetings now facilitates these workgroups by sharing their expertise in special needs, school health issue and environmental influences such as lead poisoning. On-site consultations and technical assistance is provided as needed by the analyst of Health Systems Research, Inc. of Washington, DC.

D. OTHER MCH CAPACITY

The Maternal and Child Health and the Women's Health/Genetics sections, like other sections of TDH, are organized into three levels of administration and service delivery. The Central Office, consisting of a staff of 41 professional and office support personnel, addresses strategic planning, policy development, program management, contract monitoring and data analysis functions. The seven rural regional offices are responsible for the health services offered in a specified geographic area (between 10 and 14 counties), and the metropolitan regional offices are responsible for the health services offered in each metropolitan county.

Staff are primarily located in the Cordell Hull Building in downtown Nashville which houses all the central office administrative offices of the Department, including the Commissioner's office and the Bureau of Health Services' central office. The Women's Health/Genetics staff who are responsible for newborn screening follow-up are located at the State Laboratory, which is approximately six miles from the downtown office.

At both the central office and regional level, staff administer the programs mandated for women, infants and children and handle all the administrative functions including personnel management, fiscal management, systems development for the Patient Tracking Billing Management Information System (PTBMIS), outreach and coordination with other health service systems including TennCare. Staffs at the regional and local health department levels are under the supervision of the regional director and his/her staff and are not considered out-stationed central office staff.

Within central office, the Maternal and Child Health Services is organized into two primary sections. Two areas, Child and Adolescent Health and Children's Special Services, are under the direction of Theodora Pinnock, M.D. Dr. Pinnock is a pediatrician and completed a fellowship in developmental and behavioral pediatrics. As Assistant Professor of Pediatrics at Vanderbilt Medical Center, she spent five years working in family centered, community and school-based family resource centers focused on maximizing children's readiness for school. She has worked in international settings in London and West Africa in providing medical services for children and adolescents. She has had extensive experience working with a wide variety of agencies, academic medical centers, developmental centers, state legislatures and universities. Dr. Pinnock was hired as the MCH director April 22, 2003. Her curriculum vitae is in the attached file.

Child and Adolescent Health Services - This area has several major programs headed by Master's level directors with over five years public health programmatic experience. These programs include Childhood Lead Poisoning Prevention, Abstinence Education, Child Health and Development, Adolescent Health, SIDS, Help Us Grow Successfully (HUGS), Coordinated School Health, Healthy Start, Child Fatality Review and Early Childhood Comprehensive Systems.

Children's Special Services (CSHCN) - Greg Yopp, BSW, has served in a variety of roles working with children over the past 20 years. His career in public health has been solely with Children's Special Services. Over twelve years ago, Mr. Yopp began working as a Care Coordination Supervisor for CSS in rural West Tennessee. He came to Nashville in 2000 as Program Director for Care Coordination. Mr. Yopp was named State CSS Program Director in February 2002.

The other MCH programs, Genetics and Newborn Screening and Women's Health are housed in the Women's Health/Genetics Section. Margaret F. Major, MPA, RD, serves as section chief for the women's health and genetics programs and has worked in public health programs related to women and children since 1969. After 3 years of working in Brazil with international nutrition programs, she joined the Tennessee Department of Health in 1972, working in community nutrition programs, maternal and child health, family planning and women's health. Her current program responsibilities include family planning (Title X), perinatal regionalization, prenatal care, adolescent pregnancy prevention program, women's health, newborn screening, newborn hearing screening, and genetics and sickle cell centers.

Genetics and Newborn Screening Services - Mitzi Lamberth, RN, MSN, joined the Department in 1996 as the Newborn Screening Program Coordinator. Ms. Lamberth holds a Masters of Science degree in Nursing. Prior to her service with the Department, her focus was nursing in the hospital setting at Vanderbilt University Medical Center. She has been with the Department since 1996.

Within the Department of Health, support functions such as data set development, data analysis, and research are located in the Office of Policy, Planning, and Assessment (PPA). This Office houses a number of data sets which are either maintained by their staff or extracted regularly from other data systems. These data sets include WIC, birth files, death files, linked birth-death files, hospital discharge, and the birth defects registry. WIC files are a component of PTBMIS. MCH staff have access to the output data within the PTBMIS files through a system of CUBES which is maintained by the Bureau of Health Services. Staff in Health Services and the Office of Policy, Planning, and Assessment are available for assistance. Data analysis is a cooperative effort within the Department. Data for newborn screening and hearing screening are handled through the Neometrics system for the follow-up program and the State Laboratory. Personnel from MCH and PPA have teamed up to implement the Tennessee State Systems Development Initiative (SSDI) objectives. These objectives include linking of birth and death files, utilizing geocoding to identify disparities and areas to target for children with elevated blood levels, and linking birth certificates to newborn screening information and congenital birth defects.

Role of parents: In the Parents Encouraging Parents (PEP) component of the Children's Special Services Program (CSS), volunteer support parents are trained and are matched with parents of CSHCN who are experiencing a time of crisis or transition or are seeking support from other parents who have a child with the same or a similar diagnosis. PEP offers parents of CSHCN a support system that is family-centered in which they can share common experiences. Care Coordinators are assisting families with referrals for needed services to available community agencies or the Mothers Understanding Mothers (MUMS) program. Plans are under development to contract with a nonprofit agency for these services in selected geographic areas. A parent serves on the CSS Advisory Committee for the program.

Families and parents of children with hearing loss continue to be a priority for the Newborn Hearing Screening (NHS) program. Karen Dockery, parent of a child with hearing loss, continues to serve as the NHS Parent Consultant to assist with the development of family friendly educational materials and participate in the development and implementation of program policies, protocols, and in-services.

She contacts individual families for support, works closely with parents of infants and toddlers with hearing loss to present their personal stories on several parent panels, and chairs the NHS Task Force Parent Committee. NHS works in collaboration with TN-Family Voices and the three Family to Family (F2F) consultants who are located in each of the three grand regions of Tennessee. The F2F staff and Children's Special Services (CSS) Parents Encouraging Parents (PEP) staff provide family support to individual families and facilitate linking families with families that have children with similar disabilities, including hearing loss. A new hearing parent support group was formed in the Knoxville area. Families participate in the distribution of education material to hospitals, provider offices and health fairs. They have been excellent advocates. Two parents of children with hearing loss attended the March 2005 HRSA/CDC EHDI National Conference.

The University of Tennessee Genetics Center has been the recipient of a genetics planning grant from HRSA and is currently the recipient of a grant for statewide implementation (Integration of State Health Information Systems and Newborn Screening Service Systems). This grant involves staff from Women's Health/Genetics, the Office of Policy, Planning, and Assessment, and all genetics centers, a representative from a regional perinatal center, consumers, and others. The structure involves seven committees advising the direction of the project. Three parents of special needs children serve on several of these committees, including the consumer, ethics, and data collection committees.

E. STATE AGENCY COORDINATION

Maternal and Child Health and Women's Health staff at the central office, regional offices, and local health department levels are involved in numerous collaborative efforts within the Department with various programs, with other governmental departments and agencies, and with organizations and agencies outside government (universities, school systems, city/county government, hospitals, and nonprofit agencies such as March of Dimes, American Cancer Society, American Heart Association, and the Arthritis Foundation, Tennessee Suicide Prevention Network, State Minority Health Task Force, and the Council for Developmental Disabilities).

MCH has always had a strong collaborative relationship with metropolitan health departments in the state. Since these entities have separate boards of health, the state's role is to provide needed service, focused funding, training and continuing education and participation as a partner in all planning and system change initiated to improve the public's health. The six designated metro health departments receive funds through the state's contractual system. Staff in Metro Health Departments who provide MCH services are regularly included in conference calls, quarterly meetings, in-service training and planning meetings about MCH programs and services. Metro Regional Directors participate as active partners with rural Regional Directors in public health planning and new initiatives. The primary difference between these two entities is that metros report to boards of health and the mayor, while rural regional directors report to the Acting Assistant Commissioner, Bureau of Health Services.

TennCare/Medicaid: The Childhood Lead Poisoning Prevention Program has a cost-sharing protocol with TennCare for cases when an environmental investigation is conducted for a lead poisoned child on Medicaid. Project TEACH staff work with TennCare, Managed Care and Behavioral Health Organizations and providers, and the Department of Education in providing medically necessary services to children enrolled in local school systems, including coordination of services and providing outreach to the child's family, encouraging them to access appropriate TennCare services. CSS requires that all children applying for the CSS program apply for TennCare; assists families in locating a medical home, specialists and related service providers within the MCOs' provider networks; keeps TennCare informed of underserved areas and works with the MCOs to identify out-of-network providers for CSHCN. CSS participates in TennCare advocates' meetings to keep informed of changes and uses the network of state, regional, and local CSS staff for disseminating information.

This route also allows direct CSS staff and parent interaction to ensure parent understanding of the changes and improve transition of services. CSS also helps families file appeals for denied medically necessary services. All local health departments are providing outreach, advocacy, and EPSDT screenings for TennCare enrollees.

The Newborn Genetic/Metabolic Screening and Hearing Screening programs provided training to the TennCare Managed Care Organization EPSDT Coordinators on screening requirements, confirmatory diagnostic testing and follow-up systems.

Department of Children's Services (DCS): This agency is responsible for the children in state custody. The Department of Health is providing the EPSDT screenings for all these children. Other collaborations with DCS include participation with the Child Fatality Review program at both local and state levels and funding both the Healthy Start and Child Health and Development home visiting programs. CSS regional coordinators and Project TEACH staff work with the DCS regional Health Unit nurses to coordinate health services for CSHCN in state custody.

MCH staff are members of the Children's Justice Task Force, and the Child Sex Abuse Task Force, whose members are from many state government departments and community organizations. The Children's Justice Task Force, a multidisciplinary group of professionals and advocates focused on the welfare of children reported to have been abused or neglected, is charged with identifying existing problems and recommending solutions to DCS regarding the investigation and prosecution of child abuse and neglect. The Child Sex Abuse Task Force, a multidisciplinary group of professionals and advocates, is responsible for developing a plan of action for better coordination and integration of the goals, activities and funding of the Department of Children's Services pertaining to the detection, intervention, prevention and treatment of child sexual abuse.

Department of Human Services (DHS): The local health departments receive referrals from DHS as part of the Families First welfare program. Families that terminate the program are referred to the Department (DOH) for home visits in an effort to ensure that families will survive adequately without the Families First funds. The DOH home visitors assess the families, refer them to any needed services and submit reports to DHS. DHS houses the Division of Vocational Rehabilitation, TN Services for the Blind and Visually Impaired and the TN Technology Access Project. These programs work in collaboration with the CSS program. The Deaf/Blind Coordinator has participated on the Newborn Hearing Screening (NHS) Task Force since 1997. DHS offices currently serve as the place of application for Medicaid and TennCare. DHS provides CSS proof that CSS applicants have applied to TennCare. MCH has collaborated with DHS since 1996 to build a statewide network of child care resource centers which include a child care health consultant. Services provided include: technical assistance and consultation, training, and lending resource library materials and are available to all child care providers in the State. In addition, MCH through its Early Childhood Comprehensive Systems Program and its Child Care Resource Centers assist DHS in providing technical assistance for state regulated day care centers.

Department of Education (DOE): The directors of adolescent health and school health serve on the advisory committee of the Coordinated School Health Pilot (CSHP) Program. Staff are working with the CSHP director to plan school-based child obesity prevention programs in conjunction with the LeBonheur Hospital school health team in Memphis. In 2005, DOE and MCH continued their joint five year CDC grant to expand coordinated school health programs throughout the state. For FY 2005-06, they will be conducting meetings with educational stakeholders to promote the development of more coordinated school health programs.

See paragraph under TennCare related to Project TEACH. The Department of Education, Division of Special Education, is the lead agency for the IDEA Part C, TN Early Intervention System (TEIS) for infants and toddlers birth to 3 years old identified with or having a potential for a developmental delay. TEIS has been an active participant in collaboration with the CSS program since 1990. The programs coordinate referral and care coordination activities on infants and children requiring services from both agencies. An MCH staff person serves on the State IDEA Interagency Coordinating Council

representing all MCH programs. TEIS staff serve on the NHS Task Force and the genetics implementation grant committee and have participated in joint in-services with CSS and NHS. The Tennessee Infant Parent Services (TIPS) program trains Parent Advisors to provide home-based services to infants and toddlers birth to 5 years identified with a vision and/or hearing loss, or other disability. TIPS and TEIS work closely with the NHS program and provide tracking, follow-up and intervention services for infants referred for or identified with a hearing loss after hospital hearing screening. The TEIS data collection system documents hearing follow-up and will link to NHS. An MCH staff person serves on the Part C (Early Intervention) Monitoring Review Committee. CSS central office and regional office staff participate in Early Intervention Administrators' Forums which include various agencies and promote interagency linkages at the program administrators' level. Local CSS staff participate in meetings for individual CSHCN with DOE Part C and Part B personnel in developing coordinated care plans to insure the coordination of services. CSS staff keeps DOE staff, including school health nurses, informed of TennCare changes to insure continuity of care.

Head Start: A staff person representing Head Start and Early Head Start is an active member of the TEIS State Interagency Coordinating Council; MCH works through this committee with Head Start. The DOE Head Start Collaboration Officer is a member of the Childhood Lead Poisoning Prevention Program Advisory Committee. An MCH Nursing Consultant serves on the TennCare for Children Advisory Committee and the Children's Policy Work Group with the Director of the State Head Start Collaboration office. These committees include state agency staff and advocates for children and meet regularly for discussion, information sharing and program policy coordination. The Director, along with Head Start health specialists and regional directors, has been invited to attend the MCH video-conferences to learn more about MCH programs and current diagnosis and treatment of conditions affecting children.

Mental Health/Developmental Disabilities: Staff are active members of the Child Fatality Review program at both local and state levels. MCH staff work collaboratively with the Department of Mental Health/Developmental Disabilities (TDMHDD) to assure that appropriate mental health services are accessed for children with special health care needs. Staff from Mental Health and their contracting agencies provide training for Project TEACH staff. CSS nursing consultant serves on the Council on Developmental Disabilities. CSS includes an assessment of a child's psychosocial development and refers CSHCN and family members to local mental health centers or other local MH providers if appropriate. Mental health and social-emotional development are one of the five critical areas being addressed in the Early Childhood Comprehensive Systems, and TDMHDD staff participate on the Advisory Committee. Over the last year, the MCH director has served on a statewide committee to develop a mental health system of care.

The adolescent health director serves as a member of the Tennessee Suicide Prevention Network and works with a state intradepartmental committee and the state advisory committee composed of members from the private and public sector to prevent suicide. The director co-chaired a subcommittee to address youth suicide prevention. The committee developed a state plan to address youth suicide prevention.

Social Security Administration (SSA): MCH staff provide information on MCH programs to parents of CYSHCN who have applied for SSI. The CSS program coordinates referral of children whose names are received from the SSA. The parent or guardian is sent information about possible services available to their child from state programs (CSS, Mental Health, Mental Retardation, TEIS, and the regional genetics centers).

Tennessee Bureau of Investigation (TBI): TBI staff are active members of the Child Fatality Review program at both local and state levels. CSS staff work with Corrections staff to get wheelchair ramps and custom made furniture for CYSHCN constructed at no cost to families.

Vocational Rehabilitation: See Department of Human Services.

The Commission on National and Community Service coordinates state volunteer efforts. The

adolescent health director represents the Department of Health on this commission. Members include representatives from the public and private sector who are engaged in promoting volunteer services throughout Tennessee. This MCH staff person has assisted commission members and staff as they explore the feasibility of Tennessee becoming a "State of Promise" through the America's Promise initiative.

Child Fatality Review: The Child Fatality Review process is a statewide network of multi-discipline, multi-agency teams in the 31 judicial districts in Tennessee to review all deaths of children 17 years of age or younger. Members of the local teams include: Department of Health regional health officer; Department of Human Services social services supervisor; Medical Examiner; prosecuting attorney appointed by the District Attorney General; local law enforcement officer; mental health professional; pediatrician or family practice physician; emergency medical services provider or firefighter; juvenile court representative; and representatives of other community agencies serving children. Members of the State Child Fatality team include: Department of Health commissioner; Attorney General; Department of Human Services commissioner; Tennessee Bureau of Investigation director; physician (nominated by Tennessee Medical Association); physician credentialed in forensic pathology; Department of Mental Health and Developmental Disabilities commissioner; judiciary member nominated by the Supreme Court Chief Justice; Tennessee Commission on Children and Youth chairperson; two members of the Senate; and two members of the House of Representatives.

Childhood Lead Poisoning Prevention Program: Collaborating agencies include: a) University of Tennessee Agricultural Extension Service for social marketing: to develop and distribute exhibits and brochures on childhood lead poisoning to health departments and extension agents and to analyze child blood lead level data and conduct a statewide baseline survey of Tennessee health care provider practices related to childhood lead poisoning; b) University of Tennessee Memphis for pediatrician experienced with lead poisoning in children to advise staff, partners and health care providers regarding medical case-management of children with elevated levels; and c) Tennessee Department of Environment and Conservation to conduct environmental investigations.

Adolescent Health: The adolescent health director serves on the Tennessee Healthy Weight Network. This network represents a public/private partnership of over 30 state and private organizations committed to addressing the obesity epidemic within Tennessee.

Federally Qualified Health Centers: Community Health Centers are located in medically underserved areas of the state. There are twenty-three Federally Qualified Health Centers (FQHC) that operate eighty nine clinic sites in Tennessee. These community health centers, which provide primary health care, dental and mental health services to more than 200,000 patients are slated to be a part of the "safety net" to help those slated to be disenrolled from TennCare. Referral systems exist between those community health centers and health departments located within the same county.

Early Periodic Screening, Diagnosis, and Treatment Program (EPSDT): Since July 2001, local health department clinics have assisted TennCare by providing EPSDT screenings to TennCare enrollees. The TennCare Program had difficulty in achieving desired EPSDT screening rates and is partnering with the Department to improve these rates. A Bureau of Health Services representative meets monthly with two groups in TennCare: (1) the EPSDT Workgroup comprised of representatives from all the managed care organizations; and (2) the Tennessee Chapter of the American Academy of Pediatrics representatives.

Folic Acid Education Campaign: Women's Health and Nutrition staff (central and regional offices) are partnering with the March of Dimes, Girl Scouts, and members of the state folic acid council to educate the citizens of Tennessee on the need for folic acid. Central office staff developed and implemented many of the statewide activities. The state folic acid coordinator serves as chair of the state council. The Women's Health director serves on the state council.

HIV/AIDS/STD: There is strong collaboration between the staff of the Women's Health and HIV/AIDS/STD sections. Family planning staff make referrals for HIV counseling and testing and

educate clients regarding all STDs including HIV/AIDS. With the integration of services at the local levels and the multiple functions performed by staff in the clinics, staff are very familiar with Women's Health and HIV/AIDS/STD programs. The Infertility Program (screening for chlamydia, treatment, and data analysis) is a joint project of Family Planning, STD, and the State Laboratory.

The Tennessee Breast and Cervical Cancer Early Detection Program (TBCCEDP): Seeking to educate women in Tennessee about the need for cancer screening, TBCCEDP coalition, consisting of private and public providers and advocates, meets twice a year to prioritize needs and seek solutions; central office Women's Health nursing consultant participates in these meetings. Regional MCH staff work closely with TBCCSDP coordinators.

Office of Nursing: MCH and Women's Health central office nursing staff provide program updates and serve as consultants to the regional nursing directors at their quarterly statewide Nursing Directors' meetings. The women's health nursing consultant serves as a consultant to the Public Health Nurse and Advanced Practice Nurse Committees. Continued collaboration among the Director of Nursing, the Regional Training Center in Atlanta, East Tennessee State University School of Nursing, and the Family Planning Program has resulted in the third course to train public health nurses to provide family planning clinical services.

Health Promotion and Nutrition/WIC: Collaborative efforts among MCH and Women's Health staff, Health Promotion, and Nutrition/WIC, as well as partnerships with March of Dimes and other outside agencies on activities addressing prevention of smoking in pregnant women include advertising the availability of the national QUITLINE sponsored by the American Legacy Foundation and other educational activities. CSS makes direct referrals to WIC on all clients under 5 or mothers of CSHCN who are pregnant. CSS purchases special formula if they need amounts above the allowed allocations under the WIC program. CSS also assists in obtaining special foods for PKU children.

Office of Policy, Planning and Assessment: Central office staff collaborate with the Health Statistics section on dissemination of annual releases of health data and special reports, collection of data through the joint Annual Report of Hospitals, collection of data for the Region IV Women and Infant Health Data Indicators Project, and in other MCH data projects. Women's Health staff are coordinating with this office on implementing the newborn hearing screening data system.

Tennessee Adolescent Pregnancy Prevention Program: TAPPP councils operate in four of the six metropolitan areas and in multi-county groupings in the seven rural regions. The 11 Coordinators serve as the community contacts/resource persons for adolescent pregnancy issues in their respective areas. All council memberships are broadly representative of the surrounding community, and include Girl Scouts, March of Dimes, Department of Human Services, Department of Children's Services, community-based youth serving organizations, hospitals, local businesses, schools, universities, adoption service agencies, faith-based organizations, juvenile justice agencies, media representatives, and regional and local health councils. Each council participates in a wide range of activities, depending on local priorities and resources, including conferences, parenting and adolescent heath fairs, workshops, legislative briefings, and training for professionals.

Tennessee Primary Care Association (TPCA): Department staff work closely with the TPCA primarily through the Office of Health Access, Regional and Local Health Councils, and the Women's Health Advisory Committee.
Other federal grant programs under the administration of the Department, such as WIC, family planning, abstinence education, lead, CISS, and Newborn Hearing Screening, are discussed in other sections.

Other federal grant programs under the administration of the Department, such as WIC, family planning, abstinence education, lead, CISS, and Newborn Hearing Screening, are discussed in other sections.

Identification of pregnant women and infants eligible for Medicaid: All local health department clinics

provide pregnancy testing and presumptive eligibility for Medicaid. If presumed eligible, client data are entered directly into the TennCare database at the local health department site. Women's Health staff answer the toll-free number (Baby Line) which provides information and referrals for prenatal care. Pregnant women enrolled under presumptive eligibility are referred to DHS for further enrollment beyond the presumptive time period.

F. HEALTH SYSTEMS CAPACITY INDICATORS

Data and information for the health systems capacity indicators are included on the appropriate forms as requested. Programs and activities which are addressing these indicators are discussed as follows.

#01 Health Systems Capacity Indicator - Rate of children hospitalized for asthma: Using GIS mapping, the Davidson County Public Health Department (Nashville) had identified one zip code area that had a disproportionate rate of pediatric asthma compared to the rest of the city. The Task Force met over the last year and implemented interventions in this zip code. The Task Force has recently identified a second zip code and has begun to develop possible interventions for this area. The overall goals of the project are to eliminate the asthma disparity, to decrease the number of emergency room visits due to asthma by 10%, and to decrease the number of deaths due to asthma. The task force has identified providers within the zip codes and has provided dinner meetings for them in order to encourage use of the NHLBI guidelines. Provider packets containing the guidelines were given to them. The group will continue to hold periodic roundtables during the year for community members and allow them to identify interventions.

The Bureau of TennCare has recognized asthma as being a high cost diagnosis through the managed care system. It published a document that demonstrated a recommended Asthma Care Management Program, including quality improvement measures and provider and client educational materials. All are available to providers on-line.

#02 Health Systems Capacity Indicator - Percent of Medicaid enrollees less than one year of age who received at least one initial screen: The State's emphasis on EPSDT screening for all TennCare children is discussed in various sections of this document (Agency Capacity, NPM #13, NPM #14, and SPM #7). The State's new community outreach initiative and the new Call Center should greatly increase the number of screenings.

#03 Health Systems Capacity Indicator - Percent of State Children's Health Insurance Program (SCHIP) enrollees less than one year of age who received at least one periodic screen: The State does not designate a TennCare enrollee as SCHIP or TennCare. All are considered to be TennCare enrollees.

#04 Health Systems Capacity Indicator - Prenatal visits using the Kotelchuck index: Information on the state's activities and programs addressing the needs of pregnant women is included in Agency Capacity, Other Program Activities, and NPM #8, 15, and 18.

#05 Health Systems Capacity Indicator - Comparison of health system indicators for Medicaid, non-Medicaid, and total populations: Four data items are included in this table (LBW, infant mortality, first trimester entry into prenatal care, and the Kotelchuck index). The state is unable to calculate the Kotelchuck index for the TennCare enrollees. Comparisons of the other three data elements consistently show that the total population has lower low birth weight and infant mortality rates and higher percentage of pregnant women entering prenatal care in the first trimester than the Medicaid group of women. Data over the past eight years from TennCare show that the TennCare program continues to improve the health status of women in Tennessee. The overall declines in low birth weight and in infant mortality in the TennCare population are indicative of improved outcomes in the management and care of women of childbearing age.

#06 Health Systems Capacity Indicator-Poverty level eligibility for Medicaid and for SCHIP:

The state does not differentiate between the two categories. Medicaid coverage in Tennessee continues to include: SSI eligibles, TANF eligibles, medically needy eligibles, and pregnant women and infants under age 1 up to 185% of poverty, children from 1 to 6 at 133% of poverty, and children from 6 to 19 at 100% of poverty.

#07 Health Systems Capacity Indicator-EPSDT eligible children ages 6 to 9 who have received any dental services during the year: Dental services for children are described in NPM #9 and in Agency Capacity. The number of children on TennCare ages 6 to 9 eligible for EPSDT services and receiving dental services increased significantly from June 2003 (54,648) to June 2004 (63,239) to June 2005 (72,563).

#08 Health Systems Capacity Indicator - SSI beneficiaries less than 16 in the state receiving services from the Children with Special Health Needs Program: All families with children who are newly eligible for Supplemental Security Income (SSI) are contacted by CSS and provided information on CSS, mental health, mental retardation, early intervention (TEIS), genetic services and other health department services that may be available to them. Twenty-six percent of the 6,244 CSS enrollees have SSI (FY 2004). Program staff continue to contact families with newly diagnosed children and provide information on services available. Data for 2004 show that there were 19,097 SSI recipients in the state. All were contacted by CSS staff.

#09(A) Health Systems Capacity Indicator - Ability of states to assure that the MCH program and Title V agency have access to policy and program relevant information and data:
Within the Department of Health, support functions such as data set development, data analysis, and research are located in the Office of Policy, Planning, and Assessment (PPA). This Office houses a number of data sets which are either maintained by their staff or extracted regularly from other data systems. These data sets include WIC, birth files, death files, linked birth-death files, hospital discharge, and the birth defects registry. WIC files are a component of PTBMIS. MCH staff have access to the output data within the PTBMIS files through a system of CUBES which is maintained by the Bureau of Health Services. Staff in the Bureau of Health Services and the Office of Policy, Planning, and Assessment are available to MCH for assistance. Data analysis is a cooperative effort within the Department. Data for newborn screening and newborn hearing screening are handled through the Neometrics system for Women's Health/Genetics and the State Laboratory.

The Department of Health and University of Tennessee Medical Center are partners on a 4 year HRSA grant (April 2003 - March 2007). One of the purposes of this grant is to enhance, expand, and integrate health information systems to monitor access to care and track the health status of children identified by the newborn hearing and newborn metabolic screening programs. In the Summer of 2005, a "Tennessee Child Health Profile" (TN-CHP) is being piloted from PPA servers to providers in 16 counties in and around Knoxville, Tennessee. Following the year long pilot test, plans are to expand to the other regions of the state.

Sections such as MCH do not have direct access to data, but have access through PPA or the Bureau of Health Services (HSA). The PPA staff epidemiologist assigned to MCH works with the section to provide data as necessary, to improve the quality and quantity of data sets available, and to develop the interest and commitment to address state health status issues through specific studies of data. The staff in HSA provide data and support to MCH staff for the PTBMIS data system.

Tennessee does not have a PRAMS program.

Tennessee participates in the Youth Risk Behavior Surveillance System (YRBS). The survey is administered by the Department of Education every two years. The data results are available to MCH staff. The adolescent health director works closely with staff in the Department of Education on these data and programs of mutual concern. Tennessee does not administer the Middle School YRBS survey. In order to plan more effective policy and determine more effective programming for Tennessee's middle school population, data from this group are needed.

The Genetics and Newborn Metabolic and Hearing Screening Programs use proprietary software from Neometrics to manage program data. The Case Management System contains data on all abnormal metabolic screening results, demographics on the infants, and information on follow-up and treatment. The system generates a letter to both the parents and the primary care provider to repeat the specimen. The system also allows tracking of each hospital's rate of unsatisfactory specimens. At this time, the data are not being linked to the birth files. On January 1, 2004, a field was added to the birth certificate for the specimen kit control number. It is expected that the 2005 data will be able to be linked.

The Tennessee Birth Defects Registry (TBDR) is a system housed within PPA. An annual report of Tennessee Birth Defects 2000-2002 is nearing completion. Tennessee counts for the three-year period are: anencephalus - 30 cases, and spina bifida - 77 cases. The TBDR recently initiated a program that involves sending public health nurses to selected hospitals to review infant medical records. The active review of medical records provides a depth of information not available through other passive sources (e.g. birth files and hospital discharge information). The TBDR is working toward adding birth defects information to the Department's web site.

#09(B) Health Systems Capacity Indicator-Percent of adolescents in grades 9 through 12 who report using tobacco products in the past month: This indicator is SPM #3. Data are obtained from the Youth Risk Behavior Surveillance System and available every two years. The survey is the responsibility of the Department of Education. The data results are available to MCH staff through the close working relationships of the adolescent health director in MCH and staff in the Department of Education. In addition, the Tennessee Youth Tobacco Survey provides information on use of tobacco products by youth.

#09(C) Health Systems Capacity Indicator-Ability of states to determine the percent of children who are obese or overweight: Tennessee does not have a statewide surveillance system in place to determine the obesity rate among children and youth. Data for this indicator are very limited. MCH staff participated with the Nutrition Section and others in the development of a state plan for the prevention of obesity in children through the Tennessee Healthy Weight Network (THWN). While developing the plan, network members found sporadic pockets of child/youth obesity data which included baseline data gathered among ten Coordinated School Health Programs and within the Health Department/WIC program. Data from those programs indicate that Tennessee has a problem. Coordinated School Health data show a range of 19-30% of students that are overweight, and as many as 25-43% of students who are at risk of becoming overweight. A Latino Project in Memphis found that 22-34% of children were at risk of overweight or were overweight. The Tennessee Special Supplemental Nutrition Program for Women, Infants and Children up to age 5 years has identified about 10% of children considered overweight and another 10% that are considered at risk of becoming overweight. In the THWN state plan, the need for the development of a state surveillance system was addressed. These data issues were identified during development of the Department's Better Health: It's About Time initiative.

The only source of statewide data on adolescent weight and youth perceptions of their weight, eating and exercise habits is the Tennessee Youth Behavior Risk Survey (TN YRBS). A 27.7% increase in obesity has occurred from 1999 to 2003 among Tennessee high school students. Health professionals, policy makers, youth workers, parents, youth, civic and business leaders all have an enormous challenge to work together to address these issues if Tennessee is to meet the 5% obesity goal for Healthy People 2010.

Youth Reports and Perceptions of Weight, 2003, Tennessee versus U.S., from the 2003 United States Youth Risk Behavior Surveillance Survey, Tennessee Youth Risk Behavior Survey:

At-risk of Overweight, 15% (TN), 15.4% (US)
Overweight, 15% (TN), 13.5% (US)
Self-Perception of Overweight, 31% (TN), 29.6% (US)

According to the 2003 Tennessee Youth Risk Behavioral Survey results, 15% of Tennessee's high school students are overweight, a good deal higher than the national average of 13.5%. The discrepancy among males and females in Tennessee is similar to national percentages; high school males (20.7%) are much higher than high school females (9.5%). Also, there is a discrepancy across racial lines. African American females (21.5%) are the most overweight, closely followed by white males (21.2%). From 1999-2003 white males (21.2%) became more overweight than African American males (18.3%). White females (6.3%) are more than 3 times less likely to be obese compared to their African American female counterpart (21.5%).

IV. PRIORITIES, PERFORMANCE AND PROGRAM ACTIVITIES

A. BACKGROUND AND OVERVIEW

The federal government and Tennessee partner to improve services and activities for the MCH populations in need. The process of developing a needs assessment, planning, designing and implementing programs, and allocating resources is a critical part of the public health system in Tennessee. The Needs Assessment process has been described in Section II . Section IV demonstrates progress on national and state-selected performance measures. Refer to the pyramid "Core Public Health Services Delivered by MCH Agencies" (in attached file).

Tennessee has made every effort to directly tie the priority needs of the state and the national and state performance measures to the capacity and resource capability of MCH at the local, regional and central office levels. The direct health care services offered through the public health system are in response to identified needs and gaps in service for women, infants and children. The primary emphasis of all health department activity is to assure that women, infants, and children receive the preventive care they need to reduce morbidity and mortality.

Local health departments, especially in rural areas, continue to provide direct health care services for women, infants and children. Pregnancy testing, sexually transmitted disease screening, HIV counseling and testing, and family planning services are available in every county. All counties operate WIC and nutrition services. Individual and population-based health education about the continuing and emerging health care needs of women is readily available. Infants and children can receive immunizations and well child screenings in compliance with EPSDT. These examinations include blood lead level screening in compliance with the Child Health Manual standards and EPSDT guidelines. Local health department staff follow-up with all children having elevated blood lead levels through periodic monitoring, environmental and household inspection and lead abatement activities with the families.

For children and youth with special health care needs, local nurses assist the Genetics and Newborn Screening program when an infant residing in their county needs to be located for follow-up. Children enrolled in the CSS program can receive basic well child care at the county health department with MCO approval, and the CSS care coordinators are based in each county to assist families with needed medical and referral services.

Enabling services concentrate on access to care, care coordination, home visiting services, and newborn screening follow-up. Staff at the local, regional and central office levels continue to invest significant amounts of time assisting TennCare enrollees with complex TennCare issues. These TennCare activities include outreach and advocacy, determining presumptive eligibility for pregnant women and women with breast or cervical cancer, assistance with the appeals process, referring all CSS children for TennCare enrollment, and assuring that those presumptively eligible for prenatal care are receiving needed services. The care coordination component of CSS and the PEP Program provides special support and enables families to better meet their child's needs in a complex health care environment.

Population based services are available through the activities of MCH, Women's Health, Nutrition, Health Promotion and Communicable and Environmental Disease Sections of the Bureau. These services target groups of people rather than one-on-one contact or education. Examples include: newborn metabolic screening for all newborns; newborn hearing screening; surveillance for sexually transmitted diseases; adolescent health; childhood lead poisoning prevention program; the child fatality review system; SIDS counseling and autopsies; and adolescent pregnancy prevention program. Some services at this level of the pyramid are targeted at entire groups, such as the newborn screening program. Others take a population-based approach to surveillance, as in the case of persons with diagnosed STDs, and track contacts and provide treatment. Health education activities target even broader populations in hopes that repeated messages and information will result in positive lifestyle choices to prevent morbidity and mortality.

Tennessee's current infrastructure building activities concentrate on regional and county needs assessments, quality management, data and systems planning and the development or revision of standards and guidelines. Assessment for health planning is a statewide activity through the community health councils. Each county, and in turn each region, has developed a priority list of health needs based on data; groups develop and update implementation plans and activities to address these priorities on the local level. The Bureau has staff specifically assigned to develop and oversee the quality management (QM) structure which consists of local quality units, regional quality units and a state quality council. Regional quality teams facilitate and coordinate QM at regional and local levels. The data and systems planning functions have been greatly enhanced with the availability of SSDI funds which have been used to provide support for the statewide computer network.

Training of regional and local staff is a key role of the central office. In collaboration with Vanderbilt University's MIND (Mid-Tennessee Interdisciplinary Instruction in Neurodevelopmental Disabilities) Training Program, MCH is conducting a year-long series of interactive training on MCH programs and health issues through video-conferencing statewide. This effort started with a plan for educating staff on the expansion of the newborn screening testing. MCH wanted to be assured that CSS and other health department staff were appropriately trained. Twelve videoconferences are held each year addressing current information on specific diseases and conditions, along with the treatment or clinical applications.

B. STATE PRIORITIES

The process used to define the MCH priority needs was described in the Needs Assessment detailed in Appendix of this document. Five of the state performance measures identified for 2000-2005 have remained the same. The MCH priority needs and the national and state performance measures are closely interrelated. The needs assessment activities considered all of these in the process.

Five independent activities were completed to develop the needs assessment. These activities were:
1) Analysis of primary health status data through the assistance of the Department of Health's Office of Policy, Planning and Assessment and Middle Tennessee State University.
2) Analysis of a survey developed and given to professionals that work in public and private agencies to identify the concerns of their clients and their respective communities.
3) Analysis of a survey developed and given to clients in focus groups convened throughout the state to identify concerns, needed services, and satisfaction with delivered services.
4) Review and summary of needs assessments conducted by other state organizations and advocacy groups committed to health related issues of women, children and CSHCN.
5) Citizen, MCH Needs Assessment Advisory Committee, and staff involvement through a statewide stakeholders' meeting convened by MCH.

Health statistics data were reviewed and analyzed to determine those indicators for which the rates for
Tennessee were higher than the United States as a whole. Stakeholders and MCH/Women's Health staff assisted in developing a list of ten state performance measures as priorities. The state's identified performance measures are listed as follows:

1. Increase percentage of children with complete Early Periodic Screening, Diagnosis, and Treatment (EPSDT) annual examinations by 3% each year.

2. Reduce incidence of maltreatment of children younger than 18 (physical, sexual and emotional abuse, and neglect) to rate no more than 8 per 1000.

3. Reduce the number of babies born prematurely.

4. Reduce the number of pregnant women who smoke and use illicit drugs.

5. Reduce the number of overweight and obese children and adolescents.

6. Reduce the proportion of teens and young adults (ages 15-24) with Chlamydia Trachmomatis infections attending family planning clinics.

7. Increase percentage of adolescents with complete Early Periodic Screening, Diagnosis, and Treatment (EPSDT) annual examinations by 3% each year.

8. Reduce the number of high school students using tobacco. (cigarettes and smokeless)

9. Reduce the number of high school students using alcohol.

10. Increase the percentage of youth with special health care needs, age 14 and older, who receive formal plans to transition to adulthood.

Priority setting is a continual process. With the current Administration in place, the Department has started a new strategic planning process. The Governor outlined his priorities for State Government. Two of these directly relate to health department activities and services. The Governor strongly believes every child deserves to grow up healthy and happy. He wants the state to work with families, agencies and foster parents to help protect children. He created a Children's Cabinet to encourage better cooperation between health agencies and nonprofit agencies responsible for children's welfare, including TennCare and the departments of Children's Services, Education, and Health. On June 14, 2004, the Governor announced the creation of a Governor's Office of Children's Care Coordination to coordinate the wide range of services and supports available to children through state departments and the private sector. The Governor has directed that the office's focus will be on the delivery of health care services to children. The former TennCare director is the director of the office.

The Governor has stated that TennCare is a fundamentally good initiative, but that it is critical to get TennCare back on track while ensuring that people who need appropriate medical coverage get it. As previously discussed, plans for reforming TennCare are in process. Two priorities address management of state government. The Governor believes that the way to avoid a budget crisis is to change the way state government works. He has been examining state government from top to bottom to find savings and identify more efficient practices. He has stated that strong management of state government begins with earning the taxpayer's trust, including establishing accountability in all state agencies.

With an April 2004 press conference, the Governor and the Commissioner of Health issued a wake-up call to all Tennesseans to start living healthier and make more responsible health choices. The goal of the "Better Health: It's About Time!" initiative is to raise public awareness about the importance of a healthy lifestyle, to encourage individuals to take personal responsibility for their health and well-being, and to give newborn babies a better start in life. The initiative specifically targets infant mortality, prenatal care, adolescent pregnancy, cardiovascular disease, obesity, and diabetes, and also aims to eliminate racial and ethnic health disparities in these areas. The Department of Health is working on a number of efforts to address these problems, utilizing intradepartmental strategies to focus existing resources and programs on the targeted issues, as well as intragovernmental strategies to collaborate with other departments in state government. The Department is also forming new partnerships with non-governmental agencies, community-based organizations and the faith community. The Department of Health and all sections, including maternal and child health, are involved in the development of new strategic plans for programs and activities.

The national and state performance measures and national outcome measures will be critical components of the plans.

Detailed discussion of the national and state performance measures is included in parts C and D of

this section.

C. NATIONAL PERFORMANCE MEASURES

Performance Measure 01: *The percent of newborns who are screened and confirmed with condition(s) mandated by their State-sponsored newborn screening programs (e.g. phenylketonuria and hemoglobinopathies) who receive appropriate follow up as defined by their State.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective		100	100	100	100
Annual Indicator		100.0	100.0	100.0	100.0
Numerator		78318	139	140	209
Denominator		78318	139	140	209
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	100	100	100	100	100

Notes - 2002

Data for 2001 were incorrectly reported as all births (could not change on system). Correct data for 2001 are 161 screened, confirmed, and followed-up.

Notes - 2004

All but 11 of those screened and determined presumptive positives have been confirmed for 2004.

a. Last Year's Accomplishments

The state's Genetics and Newborn Screening (NBS) Program was established in 1968 as a result of state legislation requiring PKU screening of all babies. The NBS Program has established a network of tertiary level providers for referral, case management and treatment of infants and children with genetic and metabolic diseases. Close linkages also exist between the centers and Children's Special Services for referrals. An advisory committee guides program activities and recommends changes; this committee has been vital in expanding the screening panel.

Genetics staff, located at the State Laboratory, are responsible for interfacing with the State Laboratory to identify, locate and follow up on newborns who have unsatisfactory or abnormal results from the mandated screening. Referrals are made to the genetics and sickle cell centers as well as pediatric endocrinologists. When an infant is identified as having a questionable specimen, the follow-up nurses contact the provider so that another specimen can be collected and sent to the State Laboratory or another means of confirmatory test can be done. Access to genetic screening, diagnostic testing and counseling services is available at three regional comprehensive genetic centers, two satellite genetic centers, five pediatric endocrinologists, two comprehensive sickle cell centers and two satellite sickle cell centers for individuals and

families who have or who are at risk for genetic disorders. If needed, local health department nurses assist in locating an infant needing follow-up.

This performance measure has been successfully met for many years due to the state law requiring testing of all infants born in the state and the quality and efficiency of the State Laboratory and the NBS follow-up program. During 2004, the State Laboratory installed new equipment (tandem mass spectrometry) to increase screening capabilities. Testing for maple syrup urine disease, MCAD deficiency and homocystinuria began January 2004. The State Laboratory was then screening infants for the nine diseases recommended by the March of Dimes (PKU, galactosemia, congenital hypothyroidism, congenital adrenal hyperplasia, biotinidase enzyme deficiency, hemoglobinopathies, maple syrup urine disease, medium-chain acyl coA dehydrogenase (MCAD) deficiency, and Homocystinuria). In April and July 2004 testing expanded to include additional metabolites which in different combinations relate to amino acids, organic acids or fatty acid disorders. There were 184 infants identified with one of the above diseases in 2004. All were referred for appropriate follow-up.

The State Laboratory has continually monitored the cut-off values to determine if changes need to be made based on the population of Tennesseans. The data collected are reviewed by the Genetics Advisory Committee (GAC) which includes the Genetic Centers Directors, Pediatric Endocrinologist, and others. Based upon their recommendations, cut-off values are changed.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Screen all infants born in TN for those diseases/metabolites determined by the Genetics Advisory Committee and the Department and state law.			X	
2. Follow up on all infants needing a repeat test or further diagnostic work.	X	X		
3. Work closely with Genetics and Sickle Cell Centers on follow-up and treatment.	X	X		
4. Support the Genetics Advisory Committee.			X	X
5. Work closely with all birthing facilities and health care providers on newborn screening testing and results.	X			X
6. Provide educational materials for parents and providers on newborn screening tests.	X		X	
7. Assist with re-evaluation of cut-off values for testing.			X	
8.				
9.				
10.				

b. Current Activities

Newborn screening continues to test for the diseases/metabolites discussed above using tandem mass spectrometry (TMS). As of July 2004, the Department of Health was screening for 34 diseases (which may reflect 50 different genetic disorders). All abnormal results are reported quickly following the protocols for follow-up. The program is currently screening for all core conditions, with the exception of cystic fibrosis, recommended in the "Newborn Screening: Toward a Uniform Screening Panel and System" report.

The number of presumptive positive calls increased from 1,156 in 2003 to 3,285 in 2004. This number may decrease in the future with the evaluation of the population and value cut-off changes. Evaluation of cut-off values to decrease the number of false positives is an ongoing process and a collaborative effort with the State Laboratory and the Genetics Centers.

A voice response system (VRS), developed by staff and Neometrics computer company, will be in full operation in 2005 and allow PCPs to call in and get results on an infant 24 hours a day. The PCP will need his/her license number and a PIN number to obtain results.

The NBS Follow-up Program is providing quarterly reports to all hospitals submitting specimens. The reports list the number of specimens submitted and the number which were unsatisfactory. Many of the hospitals are utilizing these reports for quality improvement and in-service training for staff that collect specimens.

Currently the program is investigating the addition of cystic fibrosis to the screening panel. A work group (Pediatric Pulmonologists, Genetics Advisory Committee(GAC) members, follow-up staff, and laboratory staff) met in early spring and recommended to the GAC that cystic fibrosis be added to the screening program. The GAC voted at the May meeting to recommend to the Department that cystic fibrosis be added to the screening panel.

The GAC, comprised of representatives from the genetic centers, Pediatric Endocrinologists, a Hematologist, and a Pediatrician/Lawyer, met twice this year to guide the program and recommend changes in tests and test procedures to the Commissioner. There were many conference calls including the above individuals to discuss the recommended value changes. The cystic fibrosis recommendation will be sent to the Commissioner of Health for his consideration.

The program continues to provide both parent and provider information on all the different metabolites and disorders. Extensive information is available on the Department of Health's web site. NBS follow-up staff are available to both providers and families to provide information and assistance.

One staff nurse attended a week's training on TMS for follow-up staff in North Carolina in May. This intense program provides staff an opportunity to network with other state programs that are now using or are planning to utilize TMS, as well as education on the analytes that are tested on the tandem mass spectrometry.

c. Plan for the Coming Year

All previously described testing and follow-up services will continue. Education of health care providers will continue, including the development of a revised training package, in DVD format, to update the training video created in November 2000 which was extremely successful in reducing unsatisfactory rates, and is still being used by birthing facilities and providers statewide. Plans will also include consideration of a web-based format for the training materials.

With the directive from the Commissioner of Health, the program will develop an implementation plan for adding cystic fibrosis to the screening panel, to include protocols, procedures, procurement of necessary equipment, evaluation of staff needs, and training of staff.

The Genetics Advisory Committee will meet at least twice during the year to address ongoing newborn screening issues such as testing for cystic fibrosis and advise the Department of Health on the direction of the screening and follow-up program.

One or two nurses from the follow-up staff will attend the newborn screening conference being held in Portland, Oregon, in October 2005. One or more members of the follow-up staff will also attend the 23rd annual SERGG meeting in Florence, Alabama, September 29, 2005 -- October 1, 2005.

Performance Measure 02: *The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive. (CSHCN survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective		90	92	94.5	96
Annual Indicator		56.2	58.0	59.3	59.3
Numerator		3384	3506	3703	3703
Denominator		6022	6044	6244	6244
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	70	70	70	70	70

Notes - 2002

The 2002 indicator is based on the State estimates from SLAITS.

Notes - 2003

The data reported in 2002 have pre-populated the data for 2003 for this performance measure.

Notes - 2004

The data reported in 2004 are pre-populated with the data from 2003 for this performance measure.

a. Last Year's Accomplishments

Children's Special Services (CSS) has continued to strengthen its relationships with parent groups, child agencies, medical providers, and other resource providers. CSS was awarded a grant from Champions for Progress by Early Intervention Research Institute from Utah State University. This grant will help establish transitional councils throughout the state which will address the holistic needs of transitioning from adolescence to adulthood. Those transitional needs will include: housing, employment, education, adult medical care, religion, transportation, recreation, shopping for personal needs, as well as other needs for a child transitioning to adulthood. The program has also re-written the policy manual for updating new information as well as making the manual more user-friendly. The rules changes are now in the final stages of being approved at which time the manual will be sent to print and then distributed to field staff.

Plans are in place for CSS clients to participate in a statewide survey for children with special

health care needs developed by Family Voices and Vanderbilt University School of Nursing. The survey tools seek to measure health care needs, challenges facing families, participation and satisfaction with current programs and family training programs.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Partner with groups who are advocates for children with special health care needs.	X			X
2. In conjunction with the child's family, develop a Family Service Plan for each child enrolled in the program	X			
3. Include parents on the CSS Advisory Board.				X
4. Conduct annual parent satisfaction surveys.		X		
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

CSS is currently working on establishing the people and resources necessary to ensure success for transitioning children to adulthood. All "traditional" transitional partners have been contacted for working toward the transitional needs and all are very willing to assist in this project. We are also beginning to contact those "non-traditional" transitional partners for their participation in this important transitional project. Some of those contacted include: private employers, recreation directors, mayors, councilmen and aldermen, religious leaders, retail and grocery store owners, transportation personnel, housing developers, as well as other community activists.

The Governor's Children's Cabinet, Family Voices, and Child Health Policymakers continue to be important partners. This partnership includes regularly scheduled meetings as well as participation in the CSS annual meeting to discuss CSHCN needs for accessing services, prioritizing needs, and presenting them to policymakers to help determine legislative action. Priorities identified at this year's meeting included a need to have a child advisory board, transitions to adulthood, and cultural competence especially with our growing Hispanic population.

Children enrolled in CSS and their families will participate in the development of a Family Service Plan (FSP). The FSP is an assessment tool from which a problems/needs list is developed. The assessment tool includes family medical and non-medical needs such as educational needs of the child as well as other family members, counseling needs, transportation needs, transitional needs, food, clothing, shelter, and employment needs. The FSP is shared with the child's primary care provider (PCP) and other agencies working with the child. Similarly, the Department of Education's early Intervention Program (Part C) develops an Individualized Family Service Plan (IFSP) and Part B develops an Individual Education Plan (IEP) which is shared with CSS and becomes part of the child's CSS record. CSS refers to and coordinates payment for medically necessary services with other agencies.

c. Plan for the Coming Year

CSS has asked that an additional parent serve on the CSS Advisory Board. It has also been suggested that if approved the parent come from the Governor's Children's Cabinet. CSS staff will continue to work with local and statewide groups on behalf of children served. Surveys will continue to be conducted with parents of children with special health care needs. Transitional services will become a key point in this upcoming fiscal year and children and parents will be active participants at all levels of decision making.

Performance Measure 03: *The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective		90	92	94.5	96
Annual Indicator		55.9	57.0	60.0	60.0
Numerator		3366	3445	3746	3746
Denominator		6022	6044	6244	6244
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	75	75	75	75	75

Notes - 2002

The 2002 indicator is based on the State estimates from SLAITS.

Notes - 2003

The data reported in 2002 have pre-populated the data for 2003 for this performance measure.

Notes - 2004

The data reported in 2004 are pre-populated with the data from 2003 for this performance measure.

a. Last Year's Accomplishments

Tennessee has defined medical home as the health care provider or primary care physician (PCP) selected by the family or assigned by the child's TennCare MCO or insurance company. If a CSS enrolled child does not have a PCP, the CSS program will assist the family in identifying a pediatrician, family practitioner or specialist to serve as their medical home. Certain system issues that existed prior to TennCare must still be addressed, such as assuring that well child care is provided along with the specialty care needed for chronic and acute conditions. Program data from 2004 indicate that 99% of CSS children had some form of health insurance. Of these, 92% were covered by TennCare and were affiliated with a PCP to serve

as a medical home. All CSS enrolled children (100%) and other children enrolled in TennCare are considered to have a medical home.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide care coordination services to each enrolled child and his/her family.		X		
2. Assist families moving from or to other states and needing CYSHCN.		X		
3. Provide training and technical assistance to CSS staff statewide as needed.				X
4. Use the monitoring system to identify each child's medical home or the need for one.				X
5. Continue to educate local primary care providers on the medical home concept.				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

CSS continues to ensure that all children with special health care needs are receiving coordinated, ongoing, comprehensive care with a medical home. Care coordinators remain the consistent link between the family, the PCP, and other providers.

c. Plan for the Coming Year

The CUBE reports will continue to be monitored for ensuring that all CSS eligible children receive services within the medical home. Program staff will continue to update and educate local primary care providers concerning the necessity of the medical home as well as other local resources available. All program policies continue to be evaluated for ensuring that coordinated, ongoing, comprehensive care within the medical home has been met.

Performance Measure 04: *The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance		90	92	94.5	96

Objective					
Annual Indicator		57.6	58.0	62.0	62.0
Numerator		3469	3506	3871	3871
Denominator		6022	6044	6244	6244
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	75	75	75	75	75

Notes - 2002

The 2002 indicator is based on the State estimates from SLAITS.

Notes - 2003

The data reported in 2002 have pre-populated the data for 2003 for this performance measure.

Notes - 2004

The data reported in 2004 are pre-populated with the data from 2003 for this performance measure.

a. Last Year's Accomplishments

The CSS program has always provided medical and specialty services for enrolled children. With implementation of TennCare, many medically necessary services are now covered by the MCO in which the child is enrolled. The CSS program provides services for those children whose needs have been denied and upheld through the appeals process by the MCO and TennCare.

The CSS program established a statewide care coordination program in 1990 open to children with special needs enrolled in the CSS program. In 1997, care coordination was expanded to serve high-risk children not enrolled in the CSS program, and services were also advertised to other families who were not eligible for CSS medical services. Care coordinators are assigned to every county in the state (95); the typical caseload is 80--120 children. Care coordinators work to assure that families are aware of and access services they need including educational and social services. Annual home visits are conducted and care coordinators are frequently involved in the Individualized Education/Family Service Plan (IEP/IFSP) meeting used to establish an agreed upon plan to address the child's needs. Families are also linked with the Parents Encouraging Parents (PEP) Program. Project TEACH, a special care coordination program operating in 42 out of a 139 school districts in the state, refers for services and determines the appropriate source of payment. Each public health region has identified one nurse to serve school systems in this capacity. Network providers who are identified with the appropriate managed care system deliver all the services.

The state's data system collects SSI status on children enrolled in Tennessee's CSHCN program called CSS. Thirty-three percent of CSS children under 18 years old were dually enrolled in SSI.

Based on TennCare and other insurance coverage information, 99% of the children enrolled in the CSS program have some form of health insurance.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

	Pyramid Level of

Activities	Service			
	DHC	ES	PBS	IB
1. Assure that all children applying for CSS services also apply for TennCare.	X			
2. Provide care coordination services to all CSS families statewide assisting families with access to medical care, utilization of services, transportation, etc.		X		
3. Assist families with any needed appeals to TennCare for denied services.		X		
4. Work with TennCare, the managed care organinzations, and providers to ensure service needs are met of this special population.		X		
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

CSS continues to update and educate families and providers concerning the latest insurance information available including TennCare coverage. The state has been given the approval to proceed with reducing the number of enrollees receiving benefits from TennCare. The state has also asked for approval for limiting the number and type of drugs presently part of TennCare benefits. The approval for drug changes has not yet been approved. The question of how this will impact the CSS program is still unanswered. It appears very likely the number of children needing to enroll in the CSS program will increase during the upcoming fiscal year.

c. Plan for the Coming Year

CSS will possibly experience an increase in the number of children being served due to the cuts in TennCare. This increase in enrollees will force CSS to become more involved in the direct medical care of the children served. Fiscally it is much more beneficial for CSS to direct its own medical clinics rather than have each eligible child to separately visit a medical specialist. CSS will continue to educate families and providers concerning medical insurance information while continuing to require application for TennCare benefits.

Performance Measure 05: *Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance		90	92	94.5	96

Objective					
Annual Indicator		76.0	78.0	80.0	80.0
Numerator		4577	4714	4995	4995
Denominator		6022	6044	6244	6244
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	90	90	90	90	90

Notes - 2002

The 2002 indicator is based on the State estimates from SLAITS.

Notes - 2003

The data reported in 2002 have pre-populated the data for 2003 for this performance measure.

Notes - 2004

The data reported in 2004 are pre-populated with the data from 2003 for this performance measure.

a. Last Year's Accomplishments

CSS continues its efforts for being the liaison for coordinating medical services for CSHCNs with other health department programs, local community resources both medically and non-medically, Department of Education, including the local school systems. Interagency team meetings are held to review and coordinate family-centered systems of care.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	**ES**	**PBS**	**IB**
1. Coordinate CSS services with other health department services (i.e. scheduling access, etc.		**X**		
2. Provide care coordination services, including referrals and linkages with community agencies, to all families participating in the program.		**X**		
3. Work with regional and local health councils to identify needs and gaps in services in specific communities.				**X**
4. Work with state agencies such as the Departments of Mental Health/Developmental Disabilities, Education, and Mental Retardation, local mental health centers, and school systems to develop a system of care approach to services for the population.				**X**
5. Conduct annual parent satisfaction surveys.		**X**		
6.				
7.				
8.				
9.				
10.				

b. Current Activities

CSS continues to identify needed services available within the community and easily accessible. Staff works closely with MCOs, insurance companies, and other providers for improving access to local services. Patient satisfaction surveys are conducted annually during regular clinic visits.

c. Plan for the Coming Year

CSS will continue to identify those community-based resources that are easily accessible.

Performance Measure 06: *The percentage of youth with special health care needs who received the services necessary to make transition to all aspects of adult life. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective		90	92	94.5	96
Annual Indicator		8.2	25.0	25.0	25.0
Numerator		494	1511	1561	1561
Denominator		6022	6044	6244	6244
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	50	50	50	50	50

Notes - 2002

Because only one of the States (Maine) met the NCHS standards for reliability for PM 6, the 2002 indicator is the national average except for Maine which has its State value noted.

Notes - 2003

The data reported in 2002 have pre-populated the data for 2003 for this performance measure.

Notes - 2004

The data reported in 2004 are pre-populated with the data from 2003 for this performance measure.

a. Last Year's Accomplishments

The CSS Family Service Plan was updated to include assessment and evaluation of services related to children 14 years of age and older that are in need of transitions to adulthood. Implementation of the new CSS FSP will be July 1, 2005. Other tools developed for use for assessment of transitional needs has been a transition checklist that addresses all phases of transitions both medically and non-medically. In-depth transitional training for staff was provided by the Kentucky Healthy and Ready to Work Program. CSS staff have identified and collaborated with those resources in the community which can best meet the needs of all

aspects for transitioning to adult life.

CSS was also awarded a transitional grant from Champions for Progress, Early Intervention Research Institute, Utah State University. This grant will focus on developing transitional councils (TTC) throughout the state that can identify those transitional resources available in the local community as well as recognizing those needed transitional services not available.

A council was created to identify community transitional resources related to: housing, education, employment, adult medical care, recreation, transportation, religious worship, grocery and personal shopping, as well as any other transitional needs for those young persons with special health care needs. TTCs will consist of both traditional and non-traditional transitional partners. Those partners will include transitional staff from DOE, DHS, DOH, as well as local community housing developers, employers, pastors, recreation and parks directors, grocer store owners/managers, transportation representatives, parents and their children with special health care needs, as well as those adults with special health care needs who have already experienced the transitional process from youth to adulthood.

TTCs will first be established in each of the larger metropolitan areas of Tennessee including; Memphis, Jackson, Columbia, Cookeville, Nashville, Knoxville, Chattanooga, and Johnson City. Once these metro TTCs have been established then TTCs in the rural counties will be developed. TTCs will identify those necessary transitional resources available in the community for meeting all transitional needs for children moving to adulthood. Those transitional resources needed but not available in the local community will be identified and funding for unmet needs will be investigated and pursued. A statewide resource book of all available transitional providers and services will be established broken out by region, county, and community.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Include transition services in the individual care plans for those clients approaching adulthood.	X	X		
2. Maintain listing of community referral resources				X
3. Assist with all appropriate referrals for these clients.		X		
4. Train CSS staff on transition issues		X		
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

CSS is in the process of identifying all "traditional" transitional partners all across the state. Once the partners have been identified, a meeting will be held to explain the plans of action for working in developing the TTCs across the state and how the transitional partners can assist in this transitional project. These identified partners will also begin working in helping CSS build a working relationship with those "non-traditional" transitional partners. The non-traditional partners will include: employers, housing developers, recreation directors, religious leaders,

retail and grocery owners, transportation, educational staff, and medical adult health care providers.

c. Plan for the Coming Year

CSS will work at identifying each and every need a child and family will have concerning the transitions to adulthood. CSS will develop transitional councils that will identify available as well as non-available transitional resources within the community. A resource guide to transitions will be developed that will be shared with all other agencies, private providers, advocacy groups, families, and any other entity interested in transitions to adulthood. CSS staff will continue to hold transitional training meetings across the state.

Performance Measure 07: *Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	87.7	91	92	90	94
Annual Indicator	88.2	87.6	85.6	78.4	77.2
Numerator	198296	66734	61258	55881	60040
Denominator	224825	76180	71563	71277	77773
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	95	95	95	95	95

Notes - 2003

In years prior to 2003, the level of completion was measured as 4 Dtap/3 Polio/1 MMR. For comparison's sake, the level of "4:3:1" for 2003 was 83.7%. In 2003, the criterion for completion was changed to 4:3:1:3:3:1.

a. Last Year's Accomplishments

Tennessee measures immunization at age 24 months through its annual immunization survey. The survey is a statistically valid sample of the immunization status of two-year-old children that is statistically valid for each of the state's administrative districts. As previously mentioned, the criteria base line has changed for this survey. The 2003 survey was comprised of 1620 children. The completion rate for that survey was 78.0%. The 2004 survey results are being analyzed currently. The regional staff of the Tennessee Immunization Program (TIP) work closely with providers within their geographic areas to provide technical assistance and information on the immunization needs of children of all ages and on the use of the registry. All health department staff have been trained to review the immunization status of any person

presenting for any type of service at the clinics and provide needed immunizations, or assist with referrals to the PCP. The Department's contractual arrangement with TennCare to provide EPSDT exams has provided additional opportunities to provide immunizations and to check current status. The 2004 immunization rate for day care children who are in compliance with the immunization law is 90.4%.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide immunizations in local health department clinics.	X			
2. Check immunization status of persons requesting any type of service at local health department clinics.	X			
3. Maintain and continue to improve the Immunization Registry software and capibility for electronic access for submission and retrieval of data.			X	X
4. Use intranet connection to increase data input by private physicians to the Immunization Registry			X	X
5. Access immunization coverage levels in the population.				X
6. Immunization staff continue to work with providers within their geopgraphic areas providing technical assistance			X	X
7.				
8.				
9.				
10.				

b. Current Activities

Current activities include: (1) identifying high-risk children and assure they are completing their immunization series; (2) performing formal assessments during site visits (known as "VFC/AFIX visits") to all providers enrolled in the VFC program to ensure efficient service delivery of vaccines to those for whom they are recommended; (3) expanding the availability of the immunization registry web site to private physicians' offices; (4) conducting immunization level assessments in population sub groups such as day care enrollees and kindergarten students, identifying those at high risk of not completing immunizations and devising strategies to reach them; (5) conducting follow-up on children born to hepatitis B surface antigen positive women to ensure receipt of HBIG and hepatitis B vaccine as recommended.

c. Plan for the Coming Year

The strategy will be much the same as this year. The major emphasis will be on the VFC/AFIX visits to the providers' offices that assure appropriate adequate use of vaccines. There will also be an emphasis on expanding the availability of the immunization registry web site and a new objective will be to increase the amount of private physician-administered vaccine doses that are reported to the immunization registry. Immunization level assessment activities will continue as well as the development of approaches to reach those less likely to complete immunizations on time. Follow-up of children born to hepatitis B surface antigen positive women will also continue.

Performance Measure 08: *The rate of birth (per 1,000) for teenagers aged 15 through 17 years.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	32	32	30	27	24
Annual Indicator	33.4	29.2	28.2	27.8	26.3
Numerator	3760	3412	3225	3203	3057
Denominator	112575	116707	114412	115376	116426
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	23	23	23	23	23

a. Last Year's Accomplishments

Calendar year 2004 data from the Family Planning Annual Report show that the program served 36,727 clients ages 19 and under--a 7.38% decrease from CY 2003. The state is providing EPSDT visits for children and adolescents in the local health departments, under contract with TennCare. During fiscal year 2004, the health department clinics performed 63,273 EPSDT screenings, of which 11,180 were to adolescents ages 12-20. These exams include assessment regarding sexual activity and referral for family planning services when needed.

Launched in April 2004, the Department's "Better Health: It's About Time!" initiative is working to eliminate racial and ethnic health disparities in the areas of adolescent pregnancy, infant mortality, and prenatal care.

The Director of Adolescent Health conducted developmental assets training for teams of 4 from each of the 10 coordinated health pilot sites. Each team included the coordinated school health coordinator, the guidance counselor, the guidance counselor supervisor, and a youth.

All state funding for the Section 510, Title V, Abstinence Education Program is provided by the Department of Health and Human Services, Administration for Children and Families (ACF). In FY 2005, Tennessee funded 21 community based, abstinence education projects across the State. Approximately 50,000 youth were served. According to information from the Tennessee Department of Health-Health Statistics and Research, pregnancy rates in many of the counties where there are funded projects have decreased in recent years. The annual Tennessee Healthy Choices for Youth Conference was conducted to which many agencies and persons interested in teen pregnancy prevention, sexually transmitted disease prevention and character/asset development were invited. More than 300 participants attended the event.

Tennessee Adolescent Pregnancy Prevention Program (TAPPP) councils operate in four of the six metropolitan areas and in multi-county groupings in the seven rural regions. The 11 coordinators serve as the community contacts/resource persons for adolescent pregnancy issues in their respective areas. All council memberships are broadly representative of the

surrounding community. Each council participates in a wide range of activities, depending on local priorities and resources. Providing community education and awareness activities for students, parents, and providers through classes in schools, in community agencies, and through health fairs, media presentations, and loans of films and materials is a TAPPP priority. Data for CY 2004 showed that statewide staff provided family life education programs to almost 69,000 students and 14,000 adults, and worked with 7,000 parents and professionals.

The Department contracts with United Neighborhood Health Serivces, a Nashville-based health care group, to staff a toll-free information line specifically for teens. Four staff members staff the line from 8:30 am to 5:00 pm Monday through Friday.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide family planning services in all 95 counties.	X			
2. Provide education in community settings related to adolescent health and prevention of risk-taking behaviors.				X
3. Continue TAPPP coordinators' activities and coalitions.				X
4. Continue the Abstinence Only Education Program community-based projects.		X		
5. Continue Community Prevention Initiative projects.		X		
6. Emphasize services for adolescents, including direct services, care coordination, and referrals, through the Better Health: It's About Time Initiative activities.			X	
7.				
8.				
9.				
10.				

b. Current Activities

During the first six months of FY 2005, 15,369 adolescent clients age 19 and under were provided services through the statewide Family Planning Program. Educational services, consultation, training, or technical assistance have been provided to 30,473 adolescents and children; 8,497 adults; 2,715 professionals; and 1,090 parents. Among the topics addressed were community awareness of teen pregnancy, health department services, sexuality education curricula review and revision, teacher training on health issues and curricula, abstinence education, parenting concerns, and adolescent/child growth and development.

Program staff from TAPPP, Abstinence Only Education, and Adolescent Health are serving on a "Better Health: It's About Time!" initiative work group to develop action plans for incorporating adolescent pregnancy prevention into all departmental contracts involving youth-serving agencies and to reduce racial and ethnic disparities in the area of adolescent pregnancy.

The 21 community based, abstinence education projects are charged with providing curricula and activities focusing on sexual abstinence until marriage and development of life skills. Each project must also facilitate one or more additional components known to promote youth development. These activities may include, but are not limited to public speaking, drama/dance skits, community service, volunteerism, t-shirt and billboard/bus plaque design contests, sports leagues, peer and adult mentoring, and college tours. In order to serve as a resource for

agencies or individuals across the state, a variety of educational brochures is made available at no cost upon request. Subject matter addresses abstinence and related issues such as promoting self-esteem, resisting negative peer pressure, healthy decision making, and parent-child communication. Schools, health departments, faith-based organizations, and other agencies benefit from this service.

The Community Prevention Initiative currently funds 70 programs in 51 counties, targeting children 0-12 who are at high risk for becoming involved in self-destructive behaviors.

The eleven regional and metropolitan county nurses who attended an Adolescent Health Care conference in Boston, MA in May 2004, returned to Tennessee and began to tackle adolescent health issues in their respective regions. A planning meeting was held in August 2004 with all of the nurses and the director of adolescent health. Subsequently, each nurse planned and provided regional adolescent health training for their staff. Throughout the year, they distributed extensive Office of Adolescent Health technical assistance information with their staff.

c. Plan for the Coming Year

MCH programs will continue to offer clinical and educational services to the adolescent population and offer support, technical assistance, and training to community agencies and other groups working towards lowering the teen pregnancy and birth rates.

The Department's "Better Health: It's About Time!" initiative will continue to target the elimination of racial and ethnic health disparities in the areas of adolescent pregnancy, infant mortality, and prenatal care. The workgroups will continue to implement the action plans developed during the last year.

The results of the systems capacity assessment tool pilot project have been shared with members of the Adolescent Health Leadership committee and will be utilized in strategic planning for adolescent health as well as incorporated into the forthcoming state adolescent health report.

The state's teen birth rate has been declining over the last decade, and projections indicate that this trend will continue. The availability of reproductive health services, health education, and community support for the prevention of teen pregnancy have all contributed to this improvement. Programs such as the Tennessee Adolescent Pregnancy Prevention Program, the Family Planning Program, the Abstinence Education Program, the Community Prevention Initiative Projects, and youth development and assets building training have provided leadership towards lowering the teen birth rate and achieving this objective.

In FY 2006 the Tennessee Abstinence Education Program plans to issue a Request for Grant Proposals. Funding will be afforded to counties shown to have higher pregnancy rates for the 10-17 year old population and a need for such resources. Community-based abstinence projects will be charged with promoting sexual abstinence for the population served and youth development. Educational brochures will be distributed upon request from nonprofit agencies and at community health fairs.

The annual Tennessee Healthy Choices for Youth Conference is scheduled to take place on September 18-20, 2005 at the Franklin Marriott Hotel in Franklin, Tennessee.

Performance Measure 09: *Percent of third grade children who have received protective sealants on at least one permanent molar tooth.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	17	17	17	17	17
Annual Indicator	13.4	14.8	9.3	9.3	22.0
Numerator	10728	11864	6476	6476	35059
Denominator	79917	80000	69314	69314	159359
Is the Data Provisional or Final?				Provisional	Final
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	25	25	25	25	25

Notes - 2002

Dental data on the population of third grade children who received sealants are not available and cannot be estimated. Previous data were obtained from a survey which has not been repeated. These data will begin to be collected during this fiscal year and will be available for future reporting periods.

Notes - 2003

These numbers are low because the children surveyed were our target population not a random sampling. These numbers represent the most at risk and underserved population and not indicative of the state as a whole.

a. Last Year's Accomplishments

Dental data on the population of third grade children with existing sealants on at least one molar was 22%. These data are from the 1997 survey of Tennessee children as reported in the Tennessee Dental Association Journal, 1998. Data as reported below will show that the number of children with sealants in Tennessee is increasing due to the efforts of the Tennessee Department of Health's School Based Dental Prevention Program. The state has aggressively developed programs and placed a great deal of emphasis on programs related to improving the oral health status and access to dental care for children.

The School Based Dental Prevention Program is a statewide, comprehensive dental prevention program for children in grades K-8 in schools with populations where 50% or more qualify for free or reduced lunch. It consists of three parts: a dental screening and referral, dental health education, and application of sealants. During FY 04 (July 1, 2003- June 30, 2004), school based dental prevention services were being delivered in all 13 regions. Data for FY 04 show that 144,020 children had dental screenings in 381 schools. The number of children screened represents a 40% increase over the FY 03 (July 1, 2002- June 30, 2003) fiscal year. Of these, 42,455 children were referred for unmet dental needs. Comprehensive preventive services (including all aspects of the preventive program) were provided in 328 schools. Full dental exams were conducted on 67,719 children. A total number of 289,956 teeth were sealed on 47,645 children. This is a 34% increase in the number of teeth sealed and a 17% increase in the number of children sealed over the 02-03 fiscal year. 159,735 children received oral health education programs at their schools by a public health hygienist. This is a 26% increase over

the 02-03 fiscal year figures. Dental outreach activities include provision of informational material for TennCare enrollment purposes and follow-up contacts for all recipients identified as having an urgent unmet dental need.

Dental services are required under EPSDT guidelines that are to be followed by managed care organizations (MCO) under contract with TennCare. However, there have consistently been significant shortages of dentists in MCO networks, and some areas of the state have had no dental services available. Efforts were begun by the Department in the spring of 2001 to improve access to dental services for low-income Tennessee children and have continued. Over this last fiscal year, the Department of Health (TDH) has continued to expand its dental program. Specifically clinical dental programs were enhanced through one-time special needs grants; preventive dental services are now provided statewide through a contract with TennCare which funds the School Based Dental Prevention Program; and three mobile dental clinics are providing comprehensive dental services to children in underserved areas.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide clinical dental services to TennCare children.	X			
2. Provide preventive dental services including sealants and oral health education to children in schools.	X	X		
3. Provide dental outreach activities.		X		
4. Provide dental services using the three mobile units in Northeast, Mid-Cumberland and West Tennessee Regions.	X	X		
5. Continue the fluoride varnish program.	X			
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The CFIT (Cavity Free in Tennessee) program is expanding throughout the state. Currently all the rural regions and one metro region are providing these expanded dental preventive services. Training is scheduled for more of the metro regions in the next year. From July 1, 2004- February 2005 approximately 3000 at-risk children have been screened, referred, and had fluoride varnish applied in Tennessee Department of Health medical clinics by nursing staff. The school based dental prevention program continues to provide comprehensive preventive dental services to underserved, at-risk children in the school setting. The clinical dental program will continue also to expand and improve existing facilities.

c. Plan for the Coming Year

The fluoride varnish manual will be updated in the upcoming year, and anticipatory guidance will be added to the existing manual. Central office staff will continue to provide support and serve as a resource for this valuable program. Central office staff will continue to support both the mobile and fixed dental clinical facilities as well as provide guidance to the School Based Dental Prevention Program.

Dental services are required under EPSDT guidelines that are to be followed by the MCOs. There are significant shortages of dentists in MCO networks, and some areas of the state have no dental services available. To counteract this shortage, the Rural Health Initiative allows health regions to submit proposals through their Regional Health Councils to establish special dental, obstetric, pediatric and/or primary care services needed in their communities. Fifteen projects have been approved for funding under this new initiative. Many have chosen to develop mobile dental services targeting school children during the school year and providing services to others during holidays and summer.

In 1997, the Tennessee Department of Health, Oral Health Services Division conducted an oral health survey in east Tennessee to determine caries prevalence, caries distribution by tooth morphology, dental treatment needs, sealant prevalence and incisor trauma prevalence in children ages 5-11. In all, 17,256 children were examined as part of the survey. This was the first survey of its kind conducted in Tennessee, and results are published in the Journal of the Tennessee Dental Association. The study found that 23% of the children age 5-11 had at least one permanent tooth sealed. The proportion of children 8 years of age with sealants was 22%, less than half the Healthy People 2000 goal but about equal to the national percentage. The survey further indicates that 75% of the caries detected are concentrated in only 10% of the children examined. The challenge to the dental community in the state is to identify this disparate population and address its dental needs. The Dental Services Program conducted a statewide survey in fall 2001 to provide statistically valid information about the oral health status of children in Tennessee. From the number of 3rd grade children screened in 2000, 13.4% had received at least one sealant. This is a 3.4% improvement over 1999. In 2001, 14.8% of third graders screened received protective sealants.

Performance Measure 10: *The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2000**	**2001**	**2002**	**2003**	**2004**
Annual Performance Objective	7.1	4.5	4.1	3.7	3
Annual Indicator	4.9	4.9	5.3	4.0	4.2
Numerator	57	58	62	48	50
Denominator	1165848	1176633	1180216	1188005	1196148
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	3	3	3	3	3

a. Last Year's Accomplishments

Injury Related Deaths Among Children: The state's rate of death from motor vehicle crashes for children ages 14 and younger has been on the decline since 1994. In 2002, there were 273 deaths (24% of all childhood fatalities) due to injury among children. The greatest numbers of childhood fatalities were due to injuries resulting from vehicular incidents (133) or 49% of all injury-related fatalities.

YOUNG OCCUPANTS INJURED IN TENNESSEE CRASHES, 1994 - 2001
Year Fatalities 14 and Under
1994 86
1995 69
1997 73
1998 70
1999 71
2000 61
2001 52
TOTAL 551

Source: Tennessee Department of Health, Maternal and Child Health Section, Bureau of Health Services, Child Fatalities in Tennessee, 2002.

Vehicular Deaths Among Children: In 2002, 133 children died in vehicle related incidents. This represents 49% of all injury related deaths and 12% of all child fatalities for 2002. In 2002, the death rate for infants less than one year, was 2.66 per 100,000 population. Male children (12.25 per 100,000 population) were most likely to die from a vehicle related incident than females (6.62 per 100,000 in the population). Whites had a slightly higher rate of death from vehicle related incidents than African Americans (9.72 versus 7.42 respectively).

Fatalities Due to Vehicular by Age, Sex and Race (N=133)

Age Number Rate Sex Number Rate Race Number Rate*
<1 2 2.66 Female 45 6.62 African American 22 7.42
1-2 4 2.67 Male 88 12.25 White 101 9.72
3-5 10 4.41 Other 5 7.91
6-8 19 8.04 Asian 1 **
9-11 13 5.31 Missing 4 **
12-14 16 6.86
15-17 69 29.66
TOTAL 133 9.51 133 9.51 133 9.51
* Rates per 100,000 population
** Rates not available

Source: Tennessee Department of Health, Maternal and Child Health Section, Bureau of Health Services, Child Fatalities in Tennessee. 2002.

In 2003, over fifty (50) organizations participated in the Child Safety Fund program which was enacted through the Child Safety Act of 1989 by the Tennessee General Assembly. During this fiscal year, a total of $149,981.74 was disbursed to hospitals providing obstetrical services in Tennessee for the purchase of child restraints systems.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB

1. Educate health department staff and the general public about the new child safety seat law.			X	
2. Provide child safety seat checks at local health departments and other community sites.	X			
3. Conduct injury control activities on seat belts and child safety seat usage.			X	
4. Partner with local law enforcement agencies, Safe Kids Coalition, Head Start Centers, school systems, and the Governor's Highway Safety Office.				X
5. Provide education to students, train providers, participate in exhibits and health fairs, etc. as requested.				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

In 2003, Governor Bredesen signed a law which revised the passenger restraint law. The new law went into effect July 1, 2004 and requires a child to be in a proper safety restraint system (i.e., car seat or booster seat) based upon age, weight and height when riding in a passenger vehicle. The revised law increased fines and broadened the age for protection as an impetus to increase the number of children who are properly restrained in passenger vehicles. The Child Passenger Safety law states:

• A child under age 1 or weighing 20 pounds or less must ride in a rear facing child restraint system in the rear of the vehicle when available.
• A child one (1) through three (3) years of age weighing greater than twenty pounds (20 lbs.), must ride forward facing in a child restraint system in the rear of the vehicle when available.
• A child four (4) through (8) years of age and measuring less than five feet (5') in height must ride in a belt positioning booster seat system in the rear of the vehicle when available.
• A child nine (9) through twelve (12) years of age and measuring five (5) feet or more in height must use a passenger restraint system and should ride in the back seat of the vehicle.
• A child thirteen (13) through fifteen (15) years of age must use a passenger restraint system, including seat belts.

Person(s) charged with the violation of this law will be fined fifty dollars ($50.00). Monies generated from this violation will be used for the Child Safety Fund. The Child Safety Fund disburses money to nonprofit and governmental organizations that provide services to low income families meeting the federal poverty guidelines. The organizations then must only purchase child restraint systems with the funds and distribute them to the parent or guardian of infants and children in accordance with the rules.

During 2004, the Department promulgated rules and regulations for operation of the Child Safety Fund program (CSFP) and determined entities best suited to receive funds to purchase and distribute child restraint systems. As a result, the Tennessee Department of Health solicited applications from nonprofit and governmental organizations to participate in the Child Safety Fund program. Currently, organizations from each of the thirteen health regions in Tennessee participate in the Child Safety Fund program.

There are thirty-four (34) participating organizations; fourteen (14) new participants and twenty (20) previous participants. Along with funding, organizations approved to distribute child

restraint systems will receive the information and resources needed to comply with the Child Safety Act. Currently, $32,412.07 has been disbursed and it is projected that more than $100,000 will be disbursed this fiscal year.

Also, the Department continues to demonstrate solidarity with Safe Kids, Meharry State farm alliances, Tennessee Head Start, Tennessee Child Passenger Safety Center, and local hospitals.

c. Plan for the Coming Year

The Department of Health, the Departments of Transportation and Safety and our partners will continue efforts to reduce the number of deaths and preventable injuries among children and adults due to lack of proper restraints.

Also, the Injury Prevention and Control Program of the Department of Health will formulate an operational workplan in keeping with the program's goals, which are:
• To mobilize partnerships and engage individuals at multiple levels in activities which identify risk factors and promote a reduction in unintentional injuries derived from unhealthy safety practices.
• To promote the development and implementation of initiatives and services promoting injury prevention and safety.
• To provide technical support and training.
• To work with communities and promote policy change
• To evaluate and improve programs

Source:
Tennessee Department of Health, Maternal and Child Health Section, Bureau of Health Services, Child Fatalities in Tennessee, Nashville, TN 2002.

Performance Measure 11: *Percentage of mothers who breastfeed their infants at hospital discharge.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	57.3	60	62	62	63
Annual Indicator	58.4	59.2	61.4	62.0	62.0
Numerator	46451	46364	47544	48881	49345
Denominator	79539	78318	77433	78841	79590
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**

Annual Performance Objective	64	64	64	64	64

a. Last Year's Accomplishments

Data on breastfeeding rates at hospital discharge are obtained from the Ross Mothers' Survey, an ongoing mail survey that has been conducted for many years.

Breastfeeding is widely promoted through the statewide WIC program and by other local health department staff providing services to pregnant women. All rural and metropolitan regions have breastfeeding coordinators who work with staff, clients and providers in the community. Each local health department has a breastfeeding advocate who provides services to clients. Young mothers are encouraged to breastfeed; literature is provided before delivery; and in selected counties, a counselor is in contact with the mother to support her efforts after delivery. Each of the 23 nutrition centers established through the WIC program statewide has a room exclusively used for breastfeeding mothers. These centers have a vital role in the community as a location for classes on a variety of topics including the promotion of breastfeeding. Other health departments have set aside space for use by breastfeeding mothers.

Tennessee was awarded a special $74,999 grant from USDA to promote breastfeeding using social marketing principles. The official name of the grant is "Using Loving Support to Build a Breastfeeding Friendly Community". The goal of the project is to raise public awareness, acceptance and support of breastfeeding. The grant targeted rural West Tennessee, the region of the state with the lowest breastfeeding rates. A comprehensive plan developed by WIC staff and community partners to address specific barriers in West Tennessee serves as a model for the rest of the state.

The breastfeeding rate for WIC mothers held steady at 30 percent.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Breastfeeding coordinators and advocates in every region work with health care providers, health department staff and postpartum women to assist and promote breastfeeding.	X	X		
2. Breastfeeding data are routinely collected on WIC clients.				X
3. The Baby Friendly Initiative continues in local health department clinics.	X	X		
4. An USDA grant using social marketing principals is being used to promote breastfeeding in West Tennessee.			X	
5. An USDA infrastucture grant continues to be used to do more intensive data collection and evaluation among WIC programs.				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

All breastfeeding activities as previously described continue across the state.

The Nutrition Services Section was awarded a grant, in the amount of $270,000 in fiscal year 04-05, to implement and maintain an effective breastfeeding peer counselor program. By combining peer counseling with the on-going breastfeeding promotion efforts in the Tennessee WIC program, the peer support counselor program has the potential to significantly impact breastfeeding rates among WIC participants and, most significantly, increase the harder to achieve breastfeeding duration rates. The long-range vision is to institutionalize peer counseling as a core service in WIC.

c. Plan for the Coming Year

All previously described activities to promote breastfeeding will continue.

The breastfeeding peer counselor program grant has been renewed and funded through September 30, 2006.

Performance Measure 12: *Percentage of newborns who have been screened for hearing before hospital discharge.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2000**	**2001**	**2002**	**2003**	**2004**
Annual Performance Objective	85	85	88	98	98
Annual Indicator	69.0	84.4	95.0	97.0	97.0
Numerator	53655	66100	73561	76476	77202
Denominator	77761	78318	77433	78841	79590
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	98	98	98	98	98

a. Last Year's Accomplishments

In 2004, an estimated 97% of Tennessee infants were born in a hospital with access to hearing

screening. Calendar year 2004 data indicated 84 of the total 89 birthing facilities provided hearing screening prior to hospital discharge. Five small hospitals received MCH funds to purchase hearing screening equipment; therefore as of March 2005, 100% of the birthing hospitals now have hearing screening equipment. There were 84,836 births (resident and non-resident) (provisional data per vital records) in 2004. There is not a mandate to provide hearing screening in Tennessee; however, effective January 28, 2004, a revision to the Rules and Regulations of the Genetic Screening Program requires hospitals to report hearing screening results on the blood spot form. Seventy-nine (79) of the hearing screening hospitals reported hearing screening results on 57% (48,302) of all infants. Of the 57% hearing results reported, 3.5% were referred for further testing (EHDI goal <4%). 206 follow-up evaluations were reported on infants that had not been reported by the hospital. The follow-up rate increased from 64% (2003) to 82% (2004) [national average 75%]. 71% of the infants received a retest prior to the goal of 3 months of age. In fact, 55% received the retest prior to one month of age. Reporting to date for 2004 shows that 48 infants were confirmed with hearing loss. The Title V CSS program had 58 children < 1year of age enrolled for hearing related services in 2004.

Activities for data collection, program monitoring and evaluation continue through support of the Universal Newborn Hearing Screening HRSA grant and Early Hearing Detection and Intervention (EHDI) CDC grant. The Tennessee Department of Education's IDEA Part C Child Find, Early Intervention System (TEIS) and Tennessee Infant Parent Services (TIPS) continue to provide follow-up services to assure infants return for further hearing testing. A Filemaker Pro data system provides tracking activities completed by TEIS.

Educational activities included scholarships for five audiologists to attend a Pediatric Audiology Diagnostic Workshop sponsored by the National Center for Hearing Assessment and Management (NCHAM). Other educational activities included site visits to hospitals, training for TEIS service coordinators and TIPS parent advisors, medical residents, neonatal nurses, physicians groups, and support organizations. More information about the state's hearing screening program is available on the web site of the National Center for Hearing Assessment and Management (NCHAM) (Individual State Profiles) at www.infanthearing.org and at the Centers for Disease Control and Prevention Early Hearing Detection and Intervention (EHDI) (www.cdc.gov).

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Promote newborn hearing screening in all birthing facilities.			X	
2. Promote the use of the data collection system by all birthing facilities.			X	
3. Provide technical assistance and education to providers.				X
4. Revise, as needed, the directory of hearing providers.				X
5. Coordinate referrals and follow-up on infants with abnormal results.		X		
6. Coordinate the activities of the Newborn Hearing Screening Task Force.				X
7. Distribute educational materials for parents, providers, facilities, and intervention programs.			X	X
8. Develop survey and assessment materials to monitor effectiveness of program components.				X
9.				
10.				

b. Current Activities

All screening activities continue. The number of hospitals reporting hearing screening results continues to increase as well as the number of individual hospitals, primary care providers, and audiologists reporting follow-up results to the program.

The Newborn Hearing Screening Coordinator represented the Women's Health/Genetics Section at the HRSA All Grantees meeting in October 2004. The hearing screening program collaborates with the program members from most of HRSA grantees in TN. Tennessee provided a display booth that demonstrated the partnerships of the agencies. Newborn Hearing Task Force members attended the National Early Hearing Detection and Intervention (EHDI) conference sponsored by CDC and HRSA in March 2005. Attendees included CDC EHDI grant staff, the NHS Program Coordinator, NHS Parent Consultant, the NHS Audiology Consultant, consumer, the AAP Tennessee Chapter Champion, a Tennessee Infant Parent Services (TIPS) representative and an IDEA, Part C, TEIS early intervention representative.

Educational packets (1,000) for families of children with a confirmed hearing loss have been completed and are being distributed by audiologists. The packet includes materials such as a letter from a parent, state and national hearing resources, family support agencies, communication choices, and links to the deaf community. The Tennessee list of hearing providers continues to be updated and distributed. There are currently 66 hearing screening and diagnostics provider sites, 39 hearing aid provider sites, 21 cochlear implant sites, and 35 early intervention and aural habilitation sites distributed in the three grand regions of Tennessee. A new hearing support group was initiated for families in the Knoxville area.

"Guidelines for Pediatric Audiologic Assessment and Amplification" were completed in February 2005 and distributed to audiologists, hearing providers, and Title V MCH and CSS staff in local health departments. The Guidelines were presented at the joint annual conference of the Association of Audiologists and Speech/Language Pathologists (TAASLP) and the Tennessee Chapter of the Academy of Audiologists (TAA). Posters promoting hearing screening were distributed to primary care providers and will be sent to OB/GYN providers statewide. Over 100,000 hearing brochures were reprinted. NHS data, forms and information are now on the state web site. www2.state.tn.us/health/MCH/NBS/index.htm.

c. Plan for the Coming Year

All screening activities will continue.

Survey and assessment materials are being developed to monitor hospital screening effectiveness, access to audiology and medical evaluation and parent/provider satisfaction regarding newborn hearing screening awareness and availability of materials, providers, and family support. Family Voices-TN and their Family 2 Family (F2F) consultants continue to collaborate to develop assessment/monitoring tools and to provide family support. Training will be provided to F2F and Parents Encouraging Parents staff on support and resources to families with children with hearing loss. Activities will continue to promote hearing screening and reporting of 100% of the birth population, including over 400 home births. Data collection and reporting software continue to be refined to provide timely and accurate information to assess and monitor program goals and effectiveness. A proposal to expand hearing components on the Neometrics Newborn Screening blood spot software is being considered. The expansion will enable the NHS program to monitor infants at risk for progressive hearing loss. The HRSA Hearing Screening grantees are now required to report on and monitor progress toward the relevant Healthy People 2010 performance measures. Information on these measures was submitted in May 2005 to HRSA.

Performance Measure 13: *Percent of children without health insurance.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	2	3	2.8	7	7
Annual Indicator	4.9	4.0	7.0	7.5	10.8
Numerator	71561	55941	103121	119428	173220
Denominator	1460442	1398521	1473157	1592371	1603892
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	7	7	7	7	7

Notes - 2002
Data are from Annie E. Casey Foundation publication.

a. Last Year's Accomplishments

Data on the percent of children in Tennessee without health insurance can be found in several national sources, but for varying age groups and income levels. U.S. Census Bureau, 2004 Annual Social and Economic Supplement, Current Population Survey data show that 86.8% of all persons in Tennessee and 89.2% of children under age 18 were covered by some type of health insurance. U.S. Census data for a three-year average for 2001-2003 show that 5.6% of the 61,500 children under age 19 and at or below 200% of poverty were without health insurance in the state. Data from the Children's Defense Fund show that 7.5% of children under age 19 were without health insurance in 2002, with a three-year average for 2000-2002 of 7.0%.

The state's managed care program for Medicaid recipients and the uninsured remains the major focus on providing health insurance coverage for children. In 2004, 782,057 children ages 0-21 years were enrolled in TennCare statewide. Of these, 5.9% percent were under one year of age and 18.5% were ages 6-9.

The Department has negotiated agreements with all of the MCOs operating in the rural regions to provide some traditional public health services without prior authorization. The Bureau also has agreements with selected MCOs to provide gatekeeping primary care services in eleven rural counties. Since July 2001, TennCare has requested that the local health departments assist with providing Early Periodic Screening, Diagnosis and Treatment (EPSDT) screenings to TennCare enrollees. The State had encountered difficulties in providing EPSDT. During state FY 2003, health department clinics provided 51,845 EPSDT screening. During state FY 2004, these clinics provided 63,273 EPSDT screenings.

All local health departments offer pregnancy testing and if pregnant, screen for income and enroll the women into TennCare under presumptive eligibility. Pregnant women are eligible for TennCare if under 185 percent of the federal poverty level. The information is entered into the

TennCare data base directly by health department staff so that the women are immediately on TennCare and eligible for coverage of needed services.

All children enrolled in the Children's Special Services program are required to apply for enrollment in TennCare. Ninety-three percent the children in the program receiving medical services are on TennCare. Each child is assigned to a program care coordinator who assists the family in accessing needed medical services, including preventive, routine medical care, and specialty care. The care coordinator also assists the family with the TennCare appeals process, as needed.

All local health department clinics provide advocacy and outreach for TennCare, and through contact with low income persons and families receiving a wide variety of services (home visiting, family planning, immunizations, etc.) make referrals to the Department of Human Services (DHS) for potential enrollment into TennCare.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide outreach and advocacy services in all health department clinics for TennCare enrollees.		X		
2. Provide EPSDT screenings for TennCare enrollees.	X			
3. Provide EPSDT screenings for children in state custody.	X			
4. Continue the EPSDT community outreach project.		X		
5. Provide presumptive eligibility for pregnant women in all health department clinics.		X		
6. Assist all children applying for CSS services with enrollment in TennCare.		X		
7. Assist TennCare enrolless with the TennCare appeals process.		X		
8.				
9.				
10.				

b. Current Activities

All local health department activities described in the report of last year‘s accomplishments continue. Referrals are made to the Department of Human Services (DHS) for TennCare enrollment of any families with children who may qualify. All local health department clinics provide presumptive eligibility for pregnant women to enroll in TennCare and referral to DHS for enrollment; this service not only assists with entry into prenatal care, it provides for enrollment of the infant at birth. All health department clinics provide EPSDT screening exams for children. For FY 2005, the number os screens totaled 62,884.

Currently, eleven of the rural counties are gatekeeper counties and have been assigned 15,000 TennCare clients by the managed care organizations. These enrollees include persons of all ages.

The local health departments play a major role in assurance of access to needed services through approved outreach activities to TennCare enrollees. By agreement with the Bureau of TennCare, county staff bill for advocacy activities based on the time spent in these activities on behalf of the enrollee. Examples of such activities include assistance in accessing medical care

by identifying providers and setting up appointments; reminder phone calls to the enrollee so that appointments are kept; assisting enrollees in understanding the TennCare system and appealing, when a medically necessary service is denied; and educating enrollees about the important concepts of a medical home, a primary care provider, the proper use of a hospital emergency room, preventive health education, rights and services under a managed care system.

The Department of Health, under contract with TennCare, has developed a new community outreach project to increase awareness of the availability and importance of EPSDT services. Starting in April, the Department launched its TENNderCare outreach initiative, and its two components, to encourage parents of children and youth to take advantage of free health screenings for their children. The first part is a community initiative using health educators as community coordinators. The second component is a TENNderCare Call Center. Call Center operators are providing individualized outreach to families of newly enrolled TennCare children and newly re-certified TennCare children. Parents are provided education on the importance of services and advised that the cost of these services is covered by TennCare. Appointments with the child's PCP can be made, and/or facilitated by the call center operator. Operators also assist with transportation services as needed.

c. Plan for the Coming Year

Departmental activities related to children and insurance coverage described previously will continue: enrollment of pregnant women in TennCare under presumptive eligibility; enrollment of CSS children in TennCare and assistance with access to care by the care coordinators; provision of EPSDT screenings for TennCare children; outreach and advocacy activities for TennCare enrollees; EPSDT community outreach initiative; EPSDT Call Center; provision of primary care services in selected counties; and referral of children/families to DHS for TennCare enrollment.

Performance Measure 14: *Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2000**	**2001**	**2002**	**2003**	**2004**
Annual Performance Objective	92	92	94	100	100
Annual Indicator	96.4	100.0	100.0	100.0	100.0
Numerator	623846	555961	786407	782057	775232
Denominator	647253	555961	786407	782057	775232
Is the Data Provisional or Final?				Final	Final
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance	100	100	100	100	100

Objective					

a. Last Year's Accomplishments

All Medicaid children are enrolled in the state's managed care program called TennCare. All TennCare recipients ages birth to 21 years of age are eligible for preventive health care screenings under the EPSDT program. Data from TennCare show that all children enrolled in TennCare received a paid service during 2003. Data are not available to estimate how many children in the state are potentially eligible for TennCare but who have not elected to enroll. June 2003 data from TennCare show that 57.9% of children ages 0 to 21 received a complete EPSDT exam during the year. For the total population of children on TennCare as of June 2004, there were 719,371 "expected" screenings and 527,845 actual screenings provided, for a ratio of 73.4%.

The Department of Health is helping insure that all TennCare children are receiving this important health care service. TennCare requires every MCO to contract with local health departments for EPSDT screening services. In FY 2002, the local health departments provided 43,512 EPSDT screenings. In FY 2003, the local health department clinics provided 51,845 EPSDT screenings, and in FY 2004 clinics provided 63,273 screenings.

Effective June 15, 2003, the Department of Health assumed the responsibility for screening all EPSDT eligible children in the custody of the Department of Children's Services (DCS). Data from DCS for April 2003 -- March 2004 show the 90.4% of children had completed EPSDT appointments within the past year (8,917 children). In addition, non-eligible children are also screened according to the AAP periodicity schedule.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Assist the TennCare program with marketing the need for EPSDT screening.				X
2. Provide EPSDT screenings in all local health department clinics.	X			
3. Provide outreach and advocacy services for TennCare enrollees.		X		
4. Provide EPSDT screenings for all children in custody of the Department of Children's Services.	X			
5. Continue the EPSDT community outreach project.		X		
6.				
7.				
8.				
9.				
10.				

b. Current Activities

June 2004 data from TennCare show that all children ages 0 to 21 received a service paid by Medicaid. Data also show that the EPSDT screening rate for these children had remained about the same as 2003 -- at 56.3 percent. The screening rate for children less than one year of age was 62 percent. Much emphasis is being placed on improving the screening rates,

including a direct agreement between TennCare and the Department of Health to provide screenings in local health department clinics without the need for prior authorization by the primary care provider. Results are then reported to the PCP. It is projected that approximately 60,000 screenings will be done in FY 2004 in local health department clinics.

Health department clinic staff have continued to provide outreach and advocacy activities for TennCare enrollees. Examples of such activities include assistance in accessing medical care by identifying providers and setting up appointments; reminder phone calls to the enrollee so that appointments are kept; assisting enrollees in understanding the TennCare system and appealing, when a medically necessary service is denied; and educating enrollees about the important concepts of a medical home, a primary care provider, the proper use of a hospital emergency room, preventive health education, rights and services under a managed care system.

The state maintains a contract with the Tennessee Chapter of the American Academy of Pediatrics to provide outreach to and education of pediatric providers. This includes site visits as well as participation in professional conferences to educate providers about EPSDT services and screening guidelines, as well as coding and billing procedures.

Other sections of this document provide additional information on EPSDT services in the state and the role of the local health department clinics and the Title V agency.

c. Plan for the Coming Year

All local health department activities described above will continue.

The Department of Health is in the process of implementing a community outreach project to increase awareness of the availability and importance of EPSDT services. This project is a significant expansion of EPSDT services and is targeted to a broader population of enrollees than those who are seen by the local health department clinics. The project has specific components designed to reach teens. The statewide project uses public health educators and lay outreach workers to provide outreach and education services to families with TennCare children, TennCare teens and young adults, TennCare providers, and community leaders.

The Department has implemented an EPSDT outreach call center. Outreach operators phone TennCare families who have children eligible for EPSDT screening services. The outreach operators provide education regarding the importance of preventive services; offer assistance in scheduling EPSDT appointments with either the child's primary care provider or the local health department; offer assistance with other TennCare issues; and document the outcome of the call. The call center is staffed with 13 managed call operators.

Performance Measure 15: *The percent of very low birth weight infants among all live births.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	1.5	1.5	1.6	1.5	1.5

Annual Indicator	1.7	1.7	1.7	1.7	1.4
Numerator	1329	1347	1355	1343	1129
Denominator	79539	78318	77433	78841	79590
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	1.4	1.4	1.4	1.4	1.4

a. Last Year's Accomplishments

For the past 10 years, Tennessee's very low birth weight rate has fluctuated between 1.4 and 1.7% of the births. The actual for 2003 remained at 1.7%, indicating no appreciable change. Tennessee has targeted populations at risk of adverse pregnancy outcomes for many years, including the focus on addressing access to prenatal care for TennCare enrollees and those without access to insurance. Approximately 50% of the births are to women on TennCare.

The state has five regional perinatal centers providing specialty care for high risk pregnant women and infants, as well as 24-hour consultation, transportation, professional education for providers, and technical assistance to facilities and providers. A Perinatal Advisory Committee (PAC), established by legislation and coordinated by staff in Women's Health, advises the Department on perinatal care. The state is responsible for the development, revision, and dissemination of guidelines for regionalization of perinatal care, perinatal transportation, and educational objectives for perinatal nurses and social workers. Members of the PAC and nurses working in perinatal care revised the manual "Educational Objectives for Nurses, Levels I, II, III, Neonatal Transport Nurses" during this past year. The document was distributed statewide and placed on the Department's web site. A task force of perinatal social workers revised the manual "Educational Objectives in Medicine for Perinatal Social Workers"; the document is available on the web. FY 2004 data from the centers show 13,413 deliveries, 4,235 NICU admissions, 1,186 transports, and 5,855 hours of education.

The state's large WIC program targets pregnant women as the highest priority; an average of 20,300 pregnant women receives WIC services monthly. Data for April 2005 show a caseload of 20,623 pregnant women (13.4% of the caseload). The data show that 22.6% of the caseload of pregnant women are African American.

Other programs providing services for the high risk perinatal population include pregnancy testing in all health department clinics with referral and coordination with private providers; prenatal care clinics in 11 county health department sites; TennCare eligibility for all pregnant women under 185 percent of the poverty level; and home visiting programs for pregnant women. The home visiting program is designed to reduce infant mortality and morbidity; provide care coordination; assure that EPSDT exams are received; provide parenting education and child development; and assist the mother with selecting and following a family planning method. Fiscal year 2004 data show that the program greatly expanded services to this population, making 18,836 home visits (a 4-fold increase) to 2,810 pregnant and postpartum women.

March of Dimes invested $300,000 in a three-year smoking cessation program (S.M.A.R.T. Moms), implemented in health department WIC clinics with pregnant women. Smoking cessation activities are detailed below.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continue all activities of the Perinatal Regionalization System (5 regional centers).	X			X
2. Provide pregnancy testing, counseling, referrals, presumptive eligibility for TennCare enrollment in all health department clinics.	X	X		
3. Provide WIC/Nutrition services in all local health department clinics (all counties).	X	X		
4. Provide outreach and advocacy for TennCare enrollees.		X		
5. Provide home visiting services for pregnant women.		X		
6. Offer comprehensive prenatal care services in 11 counties.	X			
7. Continue the S.M.A.R.T. Moms smoking cessation project in all WIC clinics	X	X		
8. Coordinate with the Better Health: It's About Time Initiative on activities related to access to prenatal care and reduction of Infant mortality.				X
9.				
10.				

b. Current Activities

Programs described above continue. All health department clinics offer walk-in pregnancy testing to the extent possible. The clinics maintain up-to-date referral mechanisms for assisting clients with positive pregnancy tests. In 2005, eleven counties are offering full prenatal care services in health department clinics, predominately to non-TennCare eligible Hispanic clients, who are then delivered by private physicians. All clients qualifying for TennCare presumptive eligibility are provided with assistance in locating a local physician for prenatal care and delivery. They are enrolled in WIC or CSFP, the state's two supplemental food and nutrition programs. There are 135 WIC clinics statewide.

Pregnant and postpartum women are assessed for eligibility in one of the home visiting programs. In April statewide training was provided to all home visiting staff; the HUGS conference agenda included several topics related to prevention of very low weight births, impact of prematurity, oral health in pregnant women, unintended pregnancy prevention, and adolescent risk behaviors.

The S.M.A.R.T Moms project has focused on training public and private providers to educate and assist clients in stopping smoking and on providing tools and client educational materials. This project has enhanced the intervention and education which has traditionally been a part of the WIC program. The Department is transitioning this program from March of Dimes funding to making it an integral ongoing component of WIC services. Training by videoconferencing has been provided for all staff on the project and the use of the new ACOG educational materials. Data from the three years of S.M.A.R.T. Moms show that over 17,900 health care providers have received information in a variety of settings. Over 8,593 pregnant smokers in WIC clinics received information and counseling, and 79 percent enrolled. Pregnant smokers who received the guide were more likely to quit smoking than those who did not receive the guide (24.4% vs. 21.4%).

The state's Better Health: It's About Time initiative is addressing six areas in which Tennessee compares unfavorably with other states and where there are wide gaps in the rates for various

racial and ethnic populations. Improving perinatal outcomes is the focus of three areas (infant mortality, adolescent pregnancy, and prenatal care). Maternal smoking cessation is one selective which regions may choose to address infant mortality. The West Tennessee Region is addressing maternal smoking with targeted activities. Action plans have been developed by the central office to address all three areas.

The Perinatal Advisory Committee revised the "Guidelines for Regionalization, Hospital Care Levels, Staffing and Facilities"; it is available on the web and in printed format.

The Tennessee Public Health Association fall meeting will focus on maternal and child health issues, including improving pregnancy outcomes and preventing low birth weight and infant mortality.

c. Plan for the Coming Year

The Department will continue to provide the services described above (perinatal regionalization, pregnancy testing, counseling, and referrals, WIC and nutrition services, home visiting services, prenatal care in selected counties, enrollment in TennCare under presumptive eligibility, TennCare outreach and advocacy, and S.M.A.R.T. Moms). Counties across the state will continue implementing the LifeStart components of the Better Health: It's About Time Initiative. The action plans for addressing infant mortality and low birth weight include activities for improving access to medical care, expanding care coordination and outreach services, increasing staff capacity to identify and address modifiable risk factors, reducing tobacco use, improving nutrition, reducing the number of SIDS deaths, and decreasing the number of unintended pregnancies. Central office and local health department staff will be implementing activities related to these components.

The Perinatal Advisory Committee will continue to meet throughout the year and will start the process of updating the Tennessee Perinatal Care System Guidelines for Transportation.

Staff will also work with March of Dimes committees in implementing activities related to the national prematurity prevention campaign, including a statewide prematurity summit to be held in Memphis.

Performance Measure 16: *The rate (per 100,000) of suicide deaths among youths aged 15 through 19.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	8.2	8	7.5	7	6.5
Annual Indicator	9.6	10.0	8.7	6.2	10.3
Numerator	36	40	35	25	42
Denominator	376371	398800	401132	404366	407744
Is the Data Provisional or				Final	Provisional

Final?					
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	6	6	6	6	6

a. Last Year's Accomplishments

Suicide is the third leading cause of death for Tennessee teens. In 2002, the suicide rate for teens 15-19 was 8.96 deaths per 100,000 teens. Boys complete suicide at rates three to four times higher than girls. In 2003, 17.5% of Tennessee high school students seriously considered attempting suicide, compared to 16.9% nationally. In 2003, 14.1% of Tennessee high school students made a suicide plan, compared to 12.8% in 1999 and 18.5% in 1993. In 2003, 17.7% were females compared to 10.6% males. In 2003, 28.3% of Tennessee high school students reported they had felt sad and hopeless almost every day for two weeks or more in a row that stopped them from doing some usual activities (37.4% were female and 19.6% were male).

The director of adolescent health is an active member of the Tennessee Suicide Prevention Network (TSPN). She attends quarterly meetings of the network as well as planning retreats. She also attends the bi-monthly intra-departmental meetings to address suicide prevention issues. The contact information for TSPN's web site was added to the adolescent health website page. Adolescent health youth guides were developed and distributed to approximately 100,000 youth. These guides contain information about suicide warning signs and provide national and state contact numbers. Suicide prevention training was provided in several health department regions this past year. The director is in the process of writing a SAMSHA youth suicide prevention grant in partnership with the Tennessee Department of Mental Health and Developmental Disabilities. The director of adolescent health participated in Question, Persuade, Refer (QPR) suicide prevention gatekeeper training.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Assist with Suicide Prevention Awareness Day.			**X**	
2. Partner with the Suicide Prevention Network (SPN).				**X**
3. Participate on the SPN subcommittee on youth.				**X**
4. Continue to assist with carrying out the State Youth Suicide prevention Plan.			**X**	
5. Continue to distribute fact sheets on adolescent suicide prevention.				**X**
6. Provide statewide training on youth suicide prevention.				**X**
7. Distribute youth health guides statewide to providers and youth (suicide information is included).			**X**	
8.				
9.				
10.				

b. Current Activities

The director of adolescent health is planning to provide QPR suicide prevention gatekeeper training to state health department staff. She has included a lengthy section in the adolescent health data report on suicide. She plans to continue her involvement with the Tennessee Suicide Prevention Network and develop fact sheets for youth suicide prevention that will be

available via the department's website.

c. Plan for the Coming Year

The director of adolescent health will partner with the Tennessee Department of Mental Health and Developmental Disabilities and the Tennessee Suicide Prevention Network to implement the SAMSHA grant if funded. As a part of the grant proposal, all nurses working in local health departments will receive youth suicide prevention gatekeeper training. If the SAMSHA grant is not funded, MCH will purchase magnets and wallet cards to distribute to "at risk" youth and adults who work with these youths in order to educate them about warning signs and provide mental health resource numbers.

The director of adolescent health will provide QPR training to state health department staff as well as remain active in the activities of TSPN. The adolescent health youth guides will continue to be distributed throughout the state. These guides include information about the warning signs of suicide as well as contact numbers for those needing assistance. The guides will be printed in Spanish this year and distributed to Spanish-speaking youth throughout the state. Youth suicide prevention fact sheets will be developed and marketed to youth serving groups. Regional suicide prevention resource directories will be distributed to all local health departments in Tennessee.

Performance Measure 17: *Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	80	79	79.5	80	80
Annual Indicator	78.9	74.3	73.0	74.8	72.3
Numerator	1049	1001	989	1004	815
Denominator	1329	1347	1355	1343	1128
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	80	80	80	80	80

a. Last Year's Accomplishments

Data for the determination of the percentage of very low birth weight infants born in tertiary level facilities are compiled by Health Statistics. Information on facilities by level of care is collected on the Joint Annual Report of Hospitals and is only used for statistical analysis. Data from 2001-2004 show a range of 72.4% to 74.8% of VLBW babies delivered in tertiary level hospitals. Provisional data for 2004 show a decline in the number of VLBW births in high risk facilities by almost 200.

The state has five regional perinatal centers providing specialty care for high risk pregnant women and infants, as well as consultation to all health care providers within the respective geographic area. This system has been in place in the state since the 1970s and is well established and recognized. Medical staff in all five centers are available for 24 hour consultation for both high risk obstetrical and neonatal care. Education and training for providers within the geographic areas is provided by all the centers. An advisory committee, established by legislation and coordinated by Women's Health staff, advises the Department on issues and concerns related to perinatal care. The state is responsible for the development, revision, and dissemination of guidelines for regionalization of perinatal care, guidelines for perinatal transportation, and educational objectives for nurses and social workers working in perinatal care. Contracts between TennCare and the managed care organizations require that the MCOs work with the perinatal center(s) operating in their geographic area.

The changing health care environment may have played a role in the decrease in the percent of VLBW infants being born in a tertiary level hospital. However, there are also difficulties in capturing data on the level of care by facility. The system for determining level of care in the state is self-designation, not regulatory. All services within the regional perinatal centers continued during the past year. Women's Health staff continued to work with the Perinatal Advisory Committee to review and revise the regionalization guidelines. During 2004, two of the perinatal manuals ("Educational Objectives in Medicine for Perinatal Social Workers" and "Educational Objectives for Nurses, Levels I, II, III, Neonatal Transport Nurses") were revised and distributed statewide. The documents were also placed on the Department's website for easy access by health care providers and facilities.

During FY 2004, the five obstetrical perinatal centers had 11,724 deliveries for Tennessee residents (out of 79,590 provisional resident births), documented 2,040 telephone consultations and 20,653 onsite patient consultations, and taught 1,827 hours of education. Data from the five neonatal perinatal centers for the same time period show 2,904 births to Tennessee residents, of which 487 were VLBW (2004 provisional VLBW births were 1,128); 1,186 transports; 2,311 consultations; and 4,028 hours of education.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continue the perinatal regionalization system.	X			X
2. Coordinate the activities of the Perinatal Advisory Committee.				X
3. Update and revise perinatal program manuals as needed.				X
4. Coordinate with the Better Health: It’s About Time Initiative.				X
5. Work with March of Dimes on their national prematurity campaign.				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The structure of the five regional perinatal centers continues to be in place. The state (TennCare) contracts with each of the centers to support the infrastructure of the centers

(consultation, professional education, maternal-fetal and neonatal transport, post-neonatal follow-up, data collection, and site visits to hospitals upon request). Staff at all centers are available to health care providers in the appropriate geographic area to provide consultation, assistance and referral for any high risk pregnant woman or infant. The revision to the regionalization guidelines ("Guidelines for Regionalization, Hospital Care Levels, Staffing and Facilities") was completed this year; printed copies have been distributed; and the document is available on the Department's web site. Committee members have been briefed by the Commissioner of Health about the Department's Better Health: It's About Time Initiative and challenged to become active partners in implementing activities within communities which will impact perinatal outcomes.

c. Plan for the Coming Year

The state will continue to contract with the five regional perinatal centers as in the past. The Perinatal Advisory Committee will continue to advise the Department on perinatal care issues and revise manuals as needed. Work will begin on the revision to the Tennessee Perinatal Care System Guidelines for Transportation. This committee will meet at least twice during the year and more often as needed. Committee members will continue to be provided information on the Department's Better Health: It's About Time initiative.

Performance Measure 18: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	86	87	88	89	90
Annual Indicator	81.4	80.5	80.4	80.6	80.4
Numerator	64775	63016	62274	63551	64000
Denominator	79539	78318	77433	78841	79590
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	90	90	90	90	90

Notes - 2004

These data are estimates.

a. Last Year's Accomplishments

Data for 2003 show that 80.6% of pregnant women started prenatal care in the first trimester; these data show a slight increase over 2002 (80.4%). Data on the TennCare Medicaid population show that for 2001 71.2% of their enrollees entered care in the first trimester, 74.7% in 2002, and 74.8% in 2003.

Efforts to improve the rates of entry into prenatal care have concentrated on systems development and access to care issues. Prior to 1994, local health departments provided extensive prenatal care through local health department clinics and in cooperation with physicians who agreed to assist with labor and delivery services. Concurrent with these services, the statewide perinatal system developed a system to provide referral and treatment for high risk/problem pregnancies. The goal of the local health department and perinatal system effort was to assure that pregnant women have access to the level of care needed. Under managed care which started in 1994, the delivery of prenatal care shifted from local health departments to the private sector in all but a few counties (11 for FY 2004). Activities targeting this performance measure include: pregnancy testing in all county health departments with appropriate referrals to health care providers; presumptive eligibility for TennCare in all county health department clinics; prenatal care in those counties not served adequately by the private sector (services primarily are being provided to Hispanic pregnant women who are not eligible for TennCare); WIC/nutrition services; West Tennessee's Campaign for Healthier Babies; the HUGS home visiting program; and the Perinatal Regionalization System. In west Tennessee, an MCO has contracted with the health department for prenatal and postpartum home visiting as a means of improving pregnancy outcome.

The Campaign for Healthier Babies operating in Memphis and rural West Tennessee is a media and educational effort to improve rates of first trimester prenatal care entry and birth outcomes. Distribution of the Happy Birthday Baby Book began in 1993. The campaign centers around a toll-free number promoted through television, newspaper, and print materials. Pregnant women call the number to receive a free book of information and merchandise coupons which are validated at the prenatal visits. Women in the rural counties are provided the coupon book through the local health department clinics. In 2004, over 10,800 phone calls were received at the Shelby County Health Department, and 9,512 coupon books, along with folic acid, WIC, and other prenatal/infant educational information (15,925 brochures), were mailed during the year. Coupon books were also distributed in the rural counties. In 2004, the Campaign reached 90.7% of the target audience (women 18-49) an average of 11.65 times per quarter. There were 1814 sixty second television spots aired with 998 purchased and 816 donated. There were 8 active participants. Over 1.7 million people either saw or heard the messages.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide pregnancy testing, counseling, and referral, and presumptive eligibility in all local health department clinics.	X	X		
2. Provide home visiting services for pregnant women.	X	X		
3. Provide comprehensive prenatal care in 11 counties.	X			
4. Provide WIC/nutrition services in all local health department clinics.	X	X		
5. Work with the Campaign for Healthier Babies in west Tennessee.			X	X
6. Continue operating the toll free Baby Line.	X	X		
7. Implement action plans for early entry into prenatal care developed as a part of the Better Health: It's About Time Initiative.		X		X
8.				
9.				
10.				

b. Current Activities

All previously described activities continued into the current year. Emphasis continues to be placed on reaching the Hispanic pregnant women and assisting with prenatal care or arranging referrals to the private health care providers within the community. Eleven counties are offering full prenatal care services in health department clinics, predominately to non-TennCare eligible Hispanic clients. All clients qualifying for TennCare presumptive eligibility are provided with assistance in locating a local physician for prenatal care and delivery services. They are also enrolled in WIC or CSFP, the two supplemental food and nutrition programs in the state. Data on WIC clients for April 2005 show that 20,623 pregnant women were participating in the program. If available in their county, the clients are assessed for the need for home visiting services and referred to the program. Currently, 81 counties provide home visiting services.

Regional and local health department staff continually monitor the availability of prenatal care services within each geographic area, including information on which providers are taking new clients and referrals.

As previously described, the Department's statewide Better Health: It's About Time initiative is addressing efforts to decrease infant mortality and adolescent pregnancy rates and to improve rates of early entry into prenatal care. Action plans have been developed, and central office staff, regions, and counties are currently working on implementation activities. Focus areas include: improving access to prenatal care, expanding care coordination and outreach services, increasing staff capacity to identify and address modifiable risk factors, reducing tobacco use, improving nutrition, reducing the number of SIDS deaths, and decreasing the number of unintended pregnancies. Specific activities underway include materials for clients to improve referrals both within the clinic and within the community, additional training and educational updates for local clinic staff, and outreach messages for the community.

The central office continues to operate the Baby line toll free number providing callers with information on prenatal care topics and referrals to the local level as appropriate.

c. Plan for the Coming Year

All previously discussed activities will continue into the coming year. Local and regional health departments will continue to assess the need for providing prenatal care within their clinics depending upon the availability of services within the private health care systems. All health department regional offices and local clinics will be implementing various components of the Better Health: It's About Time initiative.

D. STATE PERFORMANCE MEASURES

State Performance Measure 1: *After implementation of folic acid education at the state, regional, and local levels, reduce the number of neural tube defects births.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	62	27	26	25	24

Annual Indicator					
Numerator	26	29	28	34	27
Denominator	79539		0	0	
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	23	22	22	22	22

Notes - 2002

This measure has been restated for 2001 forward to capture the number of NTD births rather than a rate or percentage. When the State's Birth Defects Registry is operational, it is expected that the number will be higher.

Notes - 2003

This measure has been restated for 2001 forward to capture the number of NTD births rather than a rate or percentage. When the State's Birth Defects Registry is operational, it is expected that the number will be higher.

Notes - 2004

This measure was restated in 2001 to capture the number of neural tube defects from the birth certificate system rather than calculate a rate or percentage.

a. Last Year's Accomplishments

Activities supporting this performance measure are the MCH/Women's Health/Nutrition collaboration for the folic acid campaign; family planning services statewide; WIC clinics and nutrition classes; collaboration with the March of Dimes (MOD); public information; media releases; Children's Special Services care coordination of those with neural tube defects; and the Tennessee Birth Defects Registry (TBDR). The TBDR, a collaborative with the National Birth Defects Prevention Network and the CDC, has provided the state with a more accurate picture of NTD prevalence. Efforts are continuing to develop an effective, ongoing birth defects monitoring and prevention program.

Education activities continued with distribution of print materials, emery boards, and bookmarks, workshops, media, web sites, paycheck messages, and exhibits. "Why Every Woman Needs Folic Acid" was reprinted (20,100). Thousands of women were targeted with folic acid information through women's shows or parenting fairs. Many others attended health department "baby fairs" and other events and meetings which included folic acid information. About 40,000 persons received paycheck messages (twice) and a payroll insert on folic acid. Vitamins purchased with money from the Vitamin Settlement were distributed though family planning, WIC and other health department clinics to non-pregnant, reproductive age women. Two indoor advertising companies placed folic acid ads in unsold spaces (Graffiti Indoor Advertising placed 120 English and 30 Spanish ads in women's restrooms in restaurants and other businesses, and InSite Advertising placed 25 English and 25 Spanish ads inside malls). CDC provided the "Before You Know You're Pregnant…" ads for this initiative. In August, county clerks were asked by mail to post a folic acid flier and distribute a folic acid brochure to couples purchasing a marriage license. Twenty counties requested more than 2,200 folic acid brochures/fliers.

The Department is responsible for coordinating/chairing the state Folic Acid Council and two MOD-funded projects: workshops on-site in 6 major employers for 19,850 workers; and a continuing education program for physicians - CME offering in a mixed media CD format

(audio, PowerPoint, and PDF file) mailed to over 5,800 physicians, physician assistants and osteopaths. Work was begun to offer the continuing education program to others and place on the web site.

MOD grant funds were used to purchase a compact with the message, "Good Health Looks Good, Folic Acid Every Day", to use with the Girl Scouts folic acid badge/patch initiative. Staff developed two publications for the Girl Scout initiative ("How to Choose a Multivitamin" and "Eat Smart, Move More, Tune In and Take a Multivitamin for Folic Acid Every Day"). Folic acid materials were distributed at the Nashville Southern Women's Show (April) and at Nashville's All About Women, a health screening/information event for 20,000 women (August).

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Expand the continuing education web-based program to nurses.				X
2. Coordinate the Tennessee Folic Acid Council.			X	X
3. Staff major exhibit at 2-day All About Women Show.			X	
4. Continue distribution of printed materials, presentations, exhibits, and media events statewide.	X		X	
5. Maintain folic acid curriculum on Department's web site; update as needed.				X
6. Distribute multivitamins to non-pregnant reproductive age women in all local health department clinics.	X			
7. Provide education materials to college and university students through student health centers and to county offices issuing marriage licenses.	X			
8. Provide training for Girl Scouts leaders and educational materials for Girl Scouts.	X			X
9. Continue expansion of the Tennessee Birth Defects Registry.			X	X
10.				

b. Current Activities

Previously discussed activities are ongoing. Funding from March of Dimes grant continues to support activities of the Tennessee Folic Acid Council through December 31, 2005. The TFAC launched its continuing education offering on the Department's web site. The offering was expanded to include Registered Dietitians in August 2004 and Pharmacists in April 2005. Additionally, the Council launched its own web site with links to and from the Department's web site in September 2004. The TFAC Girl Scouts initiative has been very successful. Since fall of 2002 when the Girl Scouts initiative began, more than 400 leaders and 3,000 girls have been educated about folic acid. Over 1,800 girls earned folic acid badges or patches.

The Department continues to provide multivitamins with folic acid to non-pregnant, reproductive age women in family planning, WIC and other health department clinics statewide. Over 1,000 bottles of folic acid only vitamins from the March of Dimes were distributed through the Nashville metropolitan health department, at three health screenings/fairs targeting minorities, during the 2005 Southern Women's Show, and at a Women's Health Month display for employees.

An additional 8,000 copies of the Spanish bookmark, "El Acido Folico Cada Dia" were reprinted in March 2005. National Folic Acid Awareness Week activities were varied and included a

mailing to 62 college, university and community college student health centers. Over 5,000 brochures and incentive items (compacts and emery boards) were sent to those requesting materials for distribution.

Development and improvement of the Tennessee Birth Defects Registry continues. An annual report of Tennessee Birth Defects 2000-2002 is nearing completion. Tennessee counts for the three-year period are: anencephalus, 30 and spina bifida, 77. The TBDR recently initiated a program that involves sending public health nurses to selected hospitals to review infant medical records. The active review of medical records provides a depth of information not available through other passive sources (birth files and hospital discharge information). The Tennessee Birth Defects Registry is working toward adding birth defect information to the Department's web site.

c. Plan for the Coming Year

This state performance measure will not be included in the new list of state measures for the next five-year cycle. However, activities will continue.

The Department, partnering with the Tennessee Folic Acid Council members, the March of Dimes, and local health department staff, will continue folic acid education activities as a major focus. Next year's activities will include continuation of workshops, distribution of materials and exhibits; possibly expanding the continuing education offering to nurses; and distribution of multivitamins through family planning, WIC and other health department clinics for non-pregnant women. Plans to provide educational materials on folic acid to college and university students through the student health centers and to offer education materials for distribution at the county offices issuing marriage licenses will continue. The folic acid badge for Girl Scouts will be listed in the fall 2005 leaders' handbook which is expected to generate continued requests for workshops and leader training sessions.

The Tennessee Birth Defects Registry will continue the collection and reporting of data on birth defects, including neural tube defects, expanding the years of data available.

State Performance Measure 2: *Reduce to no more than 4% elevated blood lead levels in children 6-72 months of age who are screened.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	4%	5	7	5	4
Annual Indicator	10.1	2.4	2.0	0.4	0.5
Numerator	1263	648	811	199	262
Denominator	12553	26614	40466	51595	49547
Is the Data Provisional or Final?				Final	Provisional

	2005	2006	2007	2008	2009
Annual Performance Objective	2	2	1	1	1

a. Last Year's Accomplishments

The Tennessee Department of Health received three one-year grant awards from the Centers for Disease Control and Prevention to implement a Childhood Lead Poisoning Prevention Program (CLPPP) beginning July 1, 2001. The goal is to identify children with elevated blood lead levels and prevent childhood lead poisoning. Program goals are four-fold: a) Monitor all blood lead levels of children less than 6 years old; b) Increase screening of children at high risk of lead exposure; c) Assure proper follow-up for children with elevated blood lead levels; and d) Increase public awareness of childhood lead poisoning and prevention. CLPPP resources are targeted to areas of highest risk of childhood lead poisoning based on old housing, children in poverty, and number of low income housing units.

Contracted partners are integral to CLPPP. The CLPPP Medical Director located at the University of Tennessee-Memphis provides consultation to health care providers regarding medical case management of children with lead poisoning. The University of Tennessee Extension Service provides CLPPP primary prevention education to the general public, parents, child care educators, 4-H and other youth, underserved and minority populations. The Department of Environment and Conservation conducts environmental investigations for children with elevated blood lead levels (EBLL).

Tennessee law requires that laboratories doing business in the State report all blood lead levels to TDH. The data are entered into a data management system at the University of Tennessee Safety Center. Children with blood lead levels >10 mcg/dl are entered into a case management system and followed until case closure through the efforts of local health departments as well as private clinics.

CDC approved $645,667 for CLPPP for FY 2004-05, the second year in the three year grant cycle. Emphasis was placed on establishing the new electronic data surveillance system.

In calendar year 2004, a total of 49,547 lead screening tests were administered to children under the age of six in Tennessee. Of those tested, 262 had lead poisoning (a confirmed elevated blood lead level >10 mcg/dl).

Of the confirmed positive cases, Shelby County had the highest number of lead poisoning cases with 47 (1.22%), Davidson County had the next highest with 62 (3.40%), Knox County was the next highest at 19 (3.04%), followed by Hamilton (8.0%), Rutherford, (3.27%) and Sullivan (25.60%).

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Collect, manage, and analyze screening data.	X		X	
2. Screen in local health department clinics, including screening in EPSDT.	X			
3. Provide case management for children with elevated blood lead levels.		X		
4. Continue education of providers and citizens.			X	

5. Develop a protocol for screening pregnant women.	X			
6. Work with tennCare providers on blood lead screening requirements.	X		X	
7.				
8.				
9.				
10.				

b. Current Activities

All activities described in the previous section continued (screening, follow-up, and education). The Department of Health has agreements with all of the TennCare managed care organizations (MCOs) to provide some traditional public health services, including blood lead screening of children without prior authorization. Local health departments continue to play a critical role in assuring access to needed services through outreach and advocacy activities. Central office provides assurance of case management. A protocol for screening pregnant women is in development.

c. Plan for the Coming Year

This state performance measure will not be included in the new list of state measures for the next five-year cycle. However, activities will continue.

All activities described above continue (screening, follow-up, and education). Specific objectives for fiscal year 2005-06 include: a) GIS Mapping and Housing Targeting; b) Matching Tennessee Medicaid/TennCare data with the CLPPP database; c) Increased partnering with community organizations and with other state/local agencies involved in environmental and child health activities; d) Collaborating with organizations and agencies involved in lead-based paint hazard reduction activities to develop protective policy and to reduce lead hazards in at least 75 housing units; e) Educating 500 professionals about the Environmental Protection Agency's (EPA's) lead-based paint notification rule and recommended practices related to lead hazard containment/clean-up; and f) Restructuring CLPPP so that essential program elements can be conducted even if funding is further reduced.

State Performance Measure 3: *Reduce the percentage of high school students using tobacco (cigarettes and smokeless tobacco).*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	35		35		30
Annual Indicator	41.3		32.4	27.6	27.6
Numerator	4113		3226	515	515
Denominator	9959		9959	1865	1865

Is the Data Provisional or Final?				Final	Final
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective		28		26	26

Notes - 2002

The Tennessee Youth Tobacco Survey is done every other year.

Notes - 2003

The 2003 Youth Risk Behavior Survey was the source

Notes - 2004

2003 Youth Behaviorial Risk Surveillance Survey

a. Last Year's Accomplishments

The Department of Health under the guidance of the CDC's Prevention Office on Smoking and Health administered the Youth Tobacco Survey (YTS). The survey is designed to collect tobacco data from the thirteen public health regions of Tennessee and provide the Department of Health regional specific data on adolescent tobacco use. The survey targeted 130 schools, grades 6-8 with respect to prevalence of tobacco use (cigarettes, smokeless tobacco, cigars and pipes); minors' access and enforcement; knowledge and attitudes; media and advertising; school curriculum; environmental tobacco exposure; and cessation. The data collected from the 2004 YTS ultimately will assist in enhancing Tennessee's capacity to design, implement and evaluate the youth component of the Tobacco Prevention and Control Program.

A two day strategic planning session hosted by the Tennessee Department of Health was convened to develop a new 5 year tobacco strategic plan to reduce and prevent tobacco use in Tennessee. The one year operational plan was also developed to identify tobacco priorities and facilitates the coordination of efforts by many diverse organizations across the state.

In an effort to address cessation needs for both youth and adults, the Tobacco Use Prevention Program began communication with Kentucky and Indiana to develop a tri-state quitline service. As a result, the Tobacco Program applied for and received a CDC Supplemental grant to establish a tri-state quitline and media campaign.

In addition, the workgroup to promote smoking cessation during pregnancy, has aligned its activities with the Department of Health's Better Health It's About Time Initiative. The members of this workgroup represent the March of Dimes; S.M.A.R.T. Moms, Vanderbilt Ingram Cancer Center; and various programs within the Tennessee Department of Health. Focus groups within four regions of the state noted that pregnant smokers needed support to quit. The workgroup developed incentive materials to further encourage pregnant women not to smoke, to not permit smoking in their environment and information for their families to support quitting. These resources were disseminated throughout regional Women Infant and Children (WIC) offices.

Tennessee funded 14 regional communities to change social norms based on their specific needs. Activities such as required mandatory education classes for students found using tobacco products on school property, a survey of physicians to determine if they assess their patient's tobacco use, how often, and what they would need to increase the frequency of performing tobacco assessments of their patients, enforcement of smoke-free facility policies in schools, court houses and health departments, publishing of retailers' names who sold to minors, after school workshops on the dangers of tobacco use, inclusion of tobacco education into school curricula and development of employee worksite wellness programs were observed all over the state.

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Collect, manage, and analyze screening data.	X		X	
2. Work with TennCare providers on blood lead screening requirements.	X		X	
3. Screen in local health department clinics, including screening EPSDT.	X			
4. Provide case management for children with elevated blood levels.		X		
5. Continue education of providers and citizens.			X	
6. Develop a protocol for screening pregnant women.	X			
7.				
8.				
9.				
10.				

b. Current Activities

The Tobacco Use Prevention and Control Program is addressing cessation for the youth of Tennessee at the local level in several ways. Two science based cessation programs targeted to youth are being used in schools across the state to promote and to provide cessation help. The programs are: the Tennessee Awareness Program (Helping Teens Stop Using Tobacco), an 8 session step by step cessation program for teens, and the Tennessee Education Group (Intervening with Teen Tobacco Users), an education support program for teen smokers. The juvenile justice system is collaborating with the local Tobacco Awareness Program (TAP) and the Tobacco Education Group (TEG) educators to use this program with youth who have violated the youth access law.

The Tobacco program in conjunction with Kentucky and Indiana will continue to develop a tri-state quitline that will serve both youth and adults in Tennessee, Kentucky and Indiana.

c. Plan for the Coming Year

1)The Tobacco Program will collaborate with CHART (Campaign for a Healthy and Responsible Tennessee), a grassroots coalition, to educate the public and motivate Tennesseans to advocate for moving policy change at the state level. The Tobacco Program through its youth empowerment focus will partner with CHART and other agencies to hold Youth Tobacco Summits in West, Middle and East Tennessee. The Youth Tobacco Summits will impart skills to empower youth to present tobacco prevention issues to their local legislatures and to civic groups and present their communities views on tobacco policy issues.

2) Smoking cessation during pregnancy workgroup will develop a media campaign to encourage the healthy development of babies by urging adults not to smoke in the presence of pregnant women. The media campaign theme "Daddy's Smoke Hurts Too" is being developed by students at Middle Tennessee State University. A media kit, CD- Rom, poster and brochures will be shared with other partners including the Tobacco Strategic Workgroup, Women Infant and Children (WIC); Smart Mothers are Resisting Tobacco (S.M.A.R.T. Moms), local affiliates of the International Childbirth Association, Inc., Tennessee Nurses Association, Tennessee Medical Association and the Tennessee Hospital Association. The smoking cessation during pregnancy workgroup will research grant and sponsorship opportunities to implement the

media campaign.
3) Tennessee will partner with Kentucky and Indiana to implement a tri-state quitline utilizing the national tobacco cessation number, 1-800-QUIT-NOW. Currently calls are routed and answered by the National Cancer Institutes (NCI) Smoking Quitline service.
4) Cessation for the youth of Tennessee will continue to be addressed at the local level via Tobacco Awareness Program (TAP), Helping Teens Stop Using Tobacco, an 8 session step by step cessation program for teens, and Tobacco Education Group (TEG), Intervening with Teen Tobacco Users. In addition, the thirteen regional health councils will identify one youth access team which will make checks to determine those retailers that sells tobacco products to minors. The information gained from this activity will be shared with retailers to educate them regarding the importance of not selling tobacco products to minors.
5) The environmental tobacco smoke (ETS) Prevention Workgroup will develop collaborate on the media campaign "Daddy's Smoke Hurts Too".
6) Tobacco coordinators will continue to incorporate Not in Mama's Kitchen into the Search Your Heart program. This is primarily a faith-based program designed to reduce exposure to secondhand smoke by encouraging African American women to prohibit smoking in their homes.

State Performance Measure 4: *Reduce the percentage of high school students using alcohol.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	40		40		38
Annual Indicator	44.2		41.1	41.1	41.1
Numerator	610		797	772	772
Denominator	1381		1940	1878	1878
Is the Data Provisional or Final?				Final	Final
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective		36		34	34

Notes - 2002

The Youth Risk Behavior Survey is completed every other year by the Department of Education.

Notes - 2003

The Youth Risk Behavior Survey was done in 2003

Notes - 2004

The Youth Behavioral Risk Surveillance Survey is done every other year. The next set of data will come in 2005

a. Last Year's Accomplishments

Compared to the national average (10.67%), Tennessee students (8.45%) report less binge drinking. However, the numbers are slightly on the increase from 1999 (8%) to 2002 (8.45%) instead of heading downward to meet the Healthy People 2010 goal of 2%. According to results from the 2003 Tennessee Youth Risk Behavior Survey (YRBS), one third of all 12th graders and nearly one fourth of all 10th graders admitted to binge drinking. Many more white high school students (30%) report binge drinking compared to African American students (11%). About 74 percent of high school youth surveyed in the 2003 Tennessee YRBS reported alcohol use at least once in their lifetime. Little difference was reported between the drinking habits of male and female high school students. More white students (75.6%) have had a drink compared to their African American counterparts (68%).

• 73.4 % of 10th graders and 80 percent of high school seniors report alcohol use at least once in their lifetime.
• 38.4 % of 10th graders and 50 percent of high school seniors report current use (defined as use in the past 30 days).
• 26% of high school students reported that they had their first drink of alcohol other than a few sips by age 12 or younger.
• 4.2% of high school students report they have had at least one drink on school property.

The Community Prevention Initiative for Children (CPIC) was established in Tennessee in 1996 to serve children and their families. The CPIC targets the reduction of high risk behaviors of youth such as teen substance use/abuse, teen pregnancy, teen violence, and school drop-out by providing prevention programs and services to children who are at highest risk for becoming involved in high risk behaviors in adolescence. The programs and services focus on reducing risk factors, enhancing protective factors and building resiliency through community-based prevention programs and services. Community members through the County and Regional Health Councils are directly involved in the planning, selection, implementation and review of the programs, services and activities provided.

The Prevention Services Division of the Bureau of Alcohol and Drug Abuse Services is responsible for technical assistance, training and support to local and statewide alcohol prevention programs. These prevention services are provided through contracts with community based organizations and are targeted to youth up to age 18. Services, programs, and initiatives include intensive focus prevention programs (structured 8-12 sessions for at-risk youth), Tennessee Teen Institute (annual event of 5 days to develop leadership, communication and planning skills to enable participants to develop initatives to help other teens), faith initiative (promotion of church involvement in outreach, training, and education for pre-adolescent children in single parent households in inner city areas), and the Tennessee Statewide Clearinghouse for Alcohol and Drug Information and Referral.

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Community Prevention Initiative will continue to fund 70 community-based programs in 51 counties that target high risk behaviors in youth.		X		X
2. Bureau of Alcohol and Drug Abuse Services will continue to fund three prevention projects; develop and support coalitions across the state; and sponsor three Teen Institutes to train teams of adults and youth in prevention strategies.		X		X
3.				
4.				

5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The Bureau of Alcohol and Drug Prevention Services is continuing the same type and level of services as described in the prior section. The Community Prevention Initiative is funding 70 programs this year. These programs are located in 51 counties and include the 4 Metropolitan counties of Knoxville, Chattanooga, Nashville, and Memphis. All of the previously mentioned activities were continued during this current year.

c. Plan for the Coming Year

The Bureau of Alcohol and Drug Abuse Services will continue with the same activities from 2004 to address adolescent alcohol usage during the upcoming year. The Community Prevention Initiative will continue similar programming for high risk youth in 2005-2006.

State Performance Measure 5: *Reduce the incidence of maltreatment of children younger than age 18 including physical, sexual, emotional abuse and neglect to a rate no more than 8 per 1,000.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2000**	**2001**	**2002**	**2003**	**2004**
Annual Performance Objective	8	7.8	7.6	7.4	7.2
Annual Indicator	7.6	6.5	6.0	7.1	10.5
Numerator	11123	9571	8853	10106	15143
Denominator	1460442	1473157	1473157	1427042	1437424
Is the Data Provisional or Final?				Final	Final
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	7.0	7	7	7	7

Notes - 2004

The DCS numbers are based on the date that the investigation is completed and classified. The numbers do not necessarily reflect the year that the abuse and/or neglect took place. Therefore, the dramatic increase in the 2004 numbers is due mainly to the department's

concerted effort to eliminate investigation backlogs. The backlog has reduced substantially and is expected to be caught up by the end of 2005. DCS reports that counting by the classification date allows for a more consistent accounting. If they reported by the incident date, then the numbers for all the years would continue to change and would be fluid. This accounting system allows for consistency. Once the case backlogs are caught up, it is expected that the victim count will stabilize and provide a more accurate assessment of trends from year to year.

a. Last Year's Accomplishments

Programs and health system activities that support this performance measure are: the mandatory reporting system; investigation by the Department of Children's Services and prosecution; community based programs for prevention education; the Child Fatality Review System; and the county home visiting programs in local health departments and contract agencies.

2004 rates regarding child abuse and neglect rates are the most current reported by the Tennessee Department of Children's Services (DCS). In 2002, 6.0 children per 1,000 were abused and/or neglected; in 2004, the rate was 10.8. While responsibility for preventing and intervening in child abuse cases resides in DCS, MCH offers a variety of intervention programs at the county level to prevent and intervene before abuse occurs. The Child Health and Development Program (CHAD) offers home visiting, parenting training, infant stimulation and basic health care to families at risk of or previously investigated regarding child abuse and/or neglect. The Healthy Start Program follows the Hawaii Healthy Start and Prevent Child Abuse America's Healthy Families America model of home visitation. Healthy Start provides assessment and referral services for families as well as intensive home visiting services for families with an elevated risk of child abuse and/or neglect. The program targets adolescent and first time parents. The Help Us Grow Successfully Program (HUGS) provides home visits to pregnant women and families of children up through age 5. All of the home visiting programs offer the opportunity to educate and counsel families and make referrals for additional services, as well as provide parent support, child development information, health care information and general parent information. All home visitors are periodically trained on the signs, symptoms and mandatory reporting requirements for suspected child abuse. Children presenting to the local health departments for a variety of services including immunizations, WIC and EPSDT are assessed for needed services related to prevention of abuse and neglect.

During FY 2003-2004, the Department provided CHAD services in 23 counties with families being referred to this program by Child Protective Services. CHAD served 1,427 children from 1,024 families in FY2004. The Healthy Start Program provided services in 26 counties, targeting first time parents who are in the prenatal period or who are at or near the time of birth. Healthy Start served 1,752 children in 1,416 families in FY2004. HUGS provided services to 74 counties. HUGS revised its guidelines and home visiting orientation manuals as well as provided developmental tools training to home visiting staff.

Tennessee has a statewide network of 11 Child Care Resource and Referral Centers, each of which provides technical assistance, training, and resources to child care providers. These consultants receive training concerning child abuse prevention, recognition and reporting.

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide home visiting services statewide to pregnant women and families of infants and young children.		X		
2. Provide technical assistance, training, and resources to child care				

porviders through the network of Child Care Resource and Referral Centers.				X
3. Make referrals for families accessing any type of health department programs and needing additional services.		X		
4. Develop and implement the long term plan for the Early Childhood Comprehensive Systems Planning grant.				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

CHAD served 23 East and Northeast Tennessee counties in fiscal year 2005. Sullivan County prepared its caseload to discontinue CHAD services and provide only HUGS services in fiscal year 2006. There will be no loss of services to families in Sullivan County through this transition. CHAD staff attended the home visiting conference. The program continues to provide support to parents as well as health, parenting and child development education.

The Healthy Start Program added Coffee County to its service provision area. The program picked up this county due to another home visiting program's loss of funding. Healthy Start serves 27 counties through its contract program. Anderson County provides service through a local initiative. This program, however, is losing its funding and is scheduled to close at the end of fiscal year 2005. New Healthy Start employees received the intensive initial training provided by Tennessee's national Healthy Families America trainer.

The CHAD and Healthy Start Program Director continued to serve on the Tennessee Children's Justice and Child Sexual Abuse Task Forces. She was also invited to work with the Tennessee Prevention Committee to develop a child abuse and neglect prevention plan for Tennessee. The Committee will make recommendations regarding the prevention system and oversee some prevention funding efforts.

HUGS provided services to 74 counties. The program is exploring ways to offer home visiting services to the 14 Tennessee counties that do not have any kind of home visiting program. A full time program director's position was established and filled during FY2005. The program provided a 3 day home visitor conference for 175 participants from across the state.

The Early Childhood Comprehensive Systems (ECCS) grant received staffing in FY 2004. Several meetings took place to create a network of representatives from public and private agencies working with children, evaluate current systems capacity, conduct a statewide needs assessment and develop a long term plan for the state. The program's goals are to have healthy growth and development and school readiness for all children.

c. Plan for the Coming Year

All home visiting programs (CHAD, Healthy Start and HUGS) will continue to provide services. CHAD will serve 22 counties since Sullivan County will drop its services at the beginning of the fiscal year. Sullivan County's HUGS program will serve any families previously served by CHAD. Healthy Start will serve 27 counties. The CHAD and Healthy Start Program Director will continue to work with the TN Prevention Committee to improve the child abuse and neglect prevention system in Tennessee. HUGS will continue to look at ways to provide home visiting

services to the 14 Tennessee counties that lack such services. HUGS will continue to provide staff training including a SIDS/grief counseling training and a training collaboration with Vanderbilt University (the MIND series). HUGS also plans to survey pediatricians and OB/GYN's to see how the program can better network with these groups. ECCS will continue to host meetings to provide public and private agency professionals the chance to collaborate to improve child health and school readiness.

State Performance Measure 6: *Reduce the number of HIV infected infants to no more than one per year*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	5	2	1	1	0
Annual Indicator			Infinity	Infinity	Infinity
Numerator	4	5	8	5	2
Denominator			0	0	0
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	0	0	0	0	0

Notes - 2002

The State is reporting cases only. The denominator is not applicable for this measure.

Notes - 2003

The State is reporting cases only. The denominator is not applicable for this measure.

Notes - 2004

The State is reporting cases only. The denominator is not applicable for this measure.

a. Last Year's Accomplishments

Programs that support this performance measure are: the state's Communicable Disease Surveillance System; the HIV/AIDS program; and Ryan White program for education, intervention and prevention of HIV/AIDS.

Primary responsibility for the reduction of HIV infected infants is within the HIV/AIDS/STD Program; however, there is strong collaboration among that branch and MCH and Women's Health. All three sections are located within the Bureau of Health Services. The directors of the sections attend bi-weekly meetings during which cross collaborations are discussed. Collaboration occurs on issues related to HIV/AIDS through the Children's Special Health Care Needs Program, Family Planning, EPSDT services, and prenatal care. Family planning and prenatal clinics at the local levels routinely make referrals for HIV counseling and testing and educate clients regarding all STDs including HIV/AIDS.

Data on pediatric HIV and pediatric AIDS have been available continuously since 1986. In November 1986, the program began gathering data on the number of infants exposed during pregnancy and birth. At that time the numbers were very fluid. That is, the numbers changed as infants who were HIV negative at 1 year of age could seroconvert the next. Also, the collecting system was such that cases were sometimes reported well after the event.

The Tennessee HIV Pregnancy Screening Act (January 1, 1998) requires that all providers of prenatal care counsel pregnant women regarding HIV infection and the need for testing, test unless refused, and counsel those testing positive. The Perinatal Advisory Committee has assisted in the dissemination of HIV/AIDS information for pregnant women and newborns to providers in their regions.

From 1999-2003 program staff investigated those babies born to HIV positive mothers. This process involved active surveillance via chart extraction directly from the hospital of delivery. Follow-up for those babies that did test positive was assured by the local health department. This grant was eliminated in 2003. In 2004 investigation continued; however, investigation then began once the lab has reported the positive test result. The process includes notifying high prevalence medical providers of possible missed opportunities in providing HIV testing and prevention.

From 1999-2003 the number of infants diagnosed as HIV averaged 5 cases a year. For 2004, the number dropped to 2. The majority of these babies were born to drug addicted mothers who had not sought prenatal care.

All health department clinics offer HIV counseling and testing services. All clinics also offer pregnancy testing and counseling; HIV testing is available to all clients testing positive for pregnancy. In those counties providing full service prenatal care, HIV counseling and testing is offered as a standard of care. Clients receiving family planning services at all 131 sites are assessed for HIV/AIDS risk behaviors, counseled regarding risk reduction behaviors, and offered testing.

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Offer HIV counseling and testing services for pregnant women in all local health department clinics.	X	X		
2. Offer pregnancy testing, HIV testing services for women with positive tests, and referrals in all local health departments.	X	X		
3. Assess risk behaviors and need for services of all family planning clients seen in local health department clinics.	X	X		
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

All services described above continue to be available.

The Tennessee Department of Health continues to support the Pregnancy Screening Act established by legislation in 1998. This legislation requires all pregnant women to receive counseling regarding the importance of testing for HIV during pregnancy; that they be tested unless they refuse, and that those found to be positive be counseled on the importance of treatment. Counseling regarding the importance of treatment emphasizes both the health of the mother and the opportunity to avoid transmitting the virus to the unborn infant. The Women's Health section will continue to collaborate with the HIV/AIDS/STD program on perinatal HIV prevention projects.

New testing technology also provides a window to decrease possible infection,even more. The rapid HIV test utilized in emergency rooms can expeditiously test those women who present for delivery without prenatal care. If a women tests positive, antiretroviral medication can be administered immediately, giving the most at risk child a chance at being HIV negative. The HIV/AIDS/STD program, in collaboration with The University of Tennessee Medical Center, a high prevalence hospital in Memphis, Tennessee, is in the process of implementing rapid HIV testing in the emergency room and labor/delivery. This initiative will have a positive impact on not only preventing perinatal infection, but also getting infected individuals into care earlier.

c. Plan for the Coming Year

This state performance measure will not be included in the new list of state measures for the next five-year cycle. However, the activities and services described in the "Current Activities" section above will continue.

State Performance Measure 9: *Increase percentage of children with complete EPSDT annual examinations by 3 percent each year.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	40.6	42	45	59	60
Annual Indicator		48.7	57.9	56.3	68.1
Numerator		271005	455474	440539	527845
Denominator	647253	555961	786407	782057	775232
Is the Data Provisional or Final?				Final	Final
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	80	80	80	80	80

a. Last Year's Accomplishments

All 95 county health departments continue to provide EPSD&T screenings to TennCare-eligible

children.

In FY 2003-04, 63,273 screenings were done. This is an increase of 11,428 screenings for the year.

As previously reported, the Department of Health assumed the responsibility of screening children in the custody of the Department of Children's Services in June 2003. Data for 2003-04 from DCS reflects that 98 percent of children had been screened.

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide advocacy and outreach activities in all local health department clinics to TennCare enrollees, including information about the need for EPSDT screening.		X		
2. Provide EPSDT screening exams to TennCare enrollees in all local health department clinics.	X			
3. Assist families with referrals to and appointments for screenings with the primary care providers.		X		
4. Provide EPSDT screening exams for all children in custody of the Department of Children's Services.	X			
5. Implement the EPSDT community outreach project.		X		
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The Department of Health, in an effort to assist TennCare in increasing the number of EPSD&T screenings to an acceptable rate, entered into a contract with the Bureau of TennCare to provide a unique approach for outreaching eligibles.

The program just became operational in April. After months of planning, the Tennessee Department of Health has begun implementation of its new program by launching a TENNderCare outreach initiative designed to encourage parents of children and youth, ages birth to 21, to take advantage of free health screenings for their children.

The Department initiated two components to its outreach program to compliment the TENNderCare logo that carries the message, "check-in, check-up, and check back." The first component is an outreach program centered around a community initiative utilizing health educators as community coordinators.

The second component of the Department's new initiative is a TENNderCare Call Center, located in Nashville. Call center operators provide individualized outreach to families of newly enrolled TennCare children and newly re-certified TennCare children. Parents are provided education on the importance of TENNderCare services and advised that the cost of these services is covered by TennCare. With agreement of the parent, the operator ontacts the

member's primary care provider (PCP) and makes an appointment for the child. If the PCP's office is open at the time of the call, the operator initiates a conference call between the member, the PCP office and the operator. If it is after hours, the operator calls the PCP's office on the next business day and follow-up with the member. The operators also help the parents make appointments for transportation services, if needed.

Appointments are made at a county health department in some instances if there is a lack of appointment slots in the primary care provider's office.

FY 2005 screenings conducted in local health department clinics totaled 62,884.

c. Plan for the Coming Year

It is projected that as many as 65,000 EPSD&T screenings will be provided in a public health clinic in FY 06.
The recently implemented TENNderCare Community Outreach program and the Call Center are now fully staffed and operational. This should result in raising the awareness of the importance of preventive care for children eligible for screenings.

State Performance Measure 10: *Reduce the proportion of teens and young adults ages 15 to 24 with chlamydia trachomatis infections attending family planning clinics*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	8.7	5.4	5.3	5.2	5.2
Annual Indicator	5.5	5.4	4.8	6.7	6.6
Numerator	1847	1955	1147	1589	1809
Denominator	33692	36285	23799	23685	27494
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	5.2	5.2	5.2	5.2	5.2

a. Last Year's Accomplishments

Chlamydia is one of the most common, treatable, sexually transmitted infections affecting women of reproductive age in the United States today. Chlamydia causes complications related to fertility and pregnancy, including increased rates of premature delivery, premature rupture of membranes and low birth weight. Tennessee, through family planning clinics and the sexually transmitted disease (STD) clinics, is providing screening and treatment statewide. The state is also participating in the Region IV Infertility Project funded through the Centers for Disease Control and Prevention. Approximately 100,000 tests are conducted annually. Both state

appropriations and federal infertility project funds are available for the program.

In January 2003, the state Laboratory switched to the Aptima Combo 2, which has greatly increased the number of positive results for chlamydia in all geographic areas, both rural and metropolitan. Data for calendar year 2004 show a positivity rate of 10.8% as compared to 6.6% for 2002.

Data by program for 2004 show that 47% of the tests were for family planning clients, with a positivity rate of 5.1%. This compares to a positivity rate of 17.4% in the STD clinic clients. Overall project data by age show a rate of 8.7% in clients under age 15, 14.2% in ages 15-19, 13.6% in ages 20-24, and 10.0% in ages 25-29. Rates by sex show 7.8% in females (74.4% of total tests) and 20.2% in males.

In January 2004, the Department approved the use of directly observed therapy (DOT) by non-medical personnel (public health representatives/disease intervention specialists) using azithromycin for the treatment of chlamydia. This policy provides an option for dealing with the most difficult patients and contacts.

In 2004, staff began conducting risk assessments and offering chlamydia urine screening to adolescents being provided EPSDT screening exams in the local health department clinics. Screening was expanded to include the Knoxville juvenile detention center.

In April the program participated in the Region IV Chlamydia Awareness Month by offering chlamydia and gonorrhea urine screening to all women presenting to the local health department clinics for a pregnancy test (excluding those who had been routinely screened in family planning). Data from this screening effort showed that this is a potential target population needing to be offered routine screening. Screening was also offered during April at 12 colleges and universities and 6 other sites such as juvenile detention, group homes, etc. Information on chlamydia was included in the Department's exhibit at the August All About Women health event in Nashville (20,000 women attended).

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Screen for chlamydia in family planning and sexually transmitted diseases clinics in local health departments.	X			
2. Provide risk assessments and screening for adolescents as part of the EPSDT screening.	X			
3. Participate on the Region IV Infertility Project Advisory Committee.				X
4. Encourage use of directly observed therapy by non-medical personnel.	X			
5. Encourage use of partner delivered therapy.	X			
6. Participate in the Region IV Chlamydia Awareness Month.	X		X	
7. Initiate discussions with state colleges on routine screening possibilities.	X			
8.				
9.				
10.				

b. Current Activities

Chlamydia screening is continuing in all family planning and sexually transmitted diseases clinics statewide. Representatives from all three programs (family planning, STD, and laboratory) continue to participate on the Region VI infertility project advisory committee. Staff continue to promote the use of partner delivered therapy in the clinics.

As part of Chlamydia Awareness Month in April 2005, urine screening for gonorrhea and chlamydia was offered on 7 college campuses statewide. An overall positivity rate of 11.6% was noted. As a result of these data, a state college has asked for resources to make this screening a routine medical service for students.

Other current year activities have included analyzing the project data from health department clinics by geographic area, by clinic type, and by age groups. Laboratory costs have greatly increased with the use of the amplified test, and several recommended options for changes to the screening criteria have been presented for Departmental consideration should there be the need for budget cuts.

c. Plan for the Coming Year

Plans include continuing all the activities described in current activities, using urine-based testing in select youth detention facilities; using urine-based testing in appropriately targeted outreach screening initiatives; and pursuing directly observed therapy by non-medical staff for treating chlamydia.

The Department is planning initial discussions with state colleges to further examine the possibility of implementing routine gonorrhea and chlamydia screening for students.

The Department will also begin planning for Chlamydia Awareness Month for 2005.

E. OTHER PROGRAM ACTIVITIES

The MCH section operates three hotlines. Two are staffed by the MCH section, and one is established with a community-based agency. The Baby Line, a toll-free telephone line, answers questions, refers callers for pregnancy testing and prenatal care within the area where they live, and responds to requests for printed material. The goal is to get women into care during the first trimester of pregnancy. Patient information is provided to TennCare high risk pregnant women enrolled in Blue Care, a TennCare MCO. Over 40 health education materials are available for distribution.

The Clearinghouse for Information on Adolescent Pregnancy Issues is a separate, central, toll-free telephone for professionals and parents seeking information on local resources, teen pregnancy statistics, resource materials, information on adolescent issues, and services.

Call GWEN is a statewide teen hotline contracted to United Neighborhood Health Services, which operates primary care centers in Nashville. The agency runs programs that provide counseling services for pregnant and parenting teens. Professional staff of the agency respond to questions and concerns. Questions concern family planning and pregnancy information, medical information and relationship issues confronting the teen caller. Factual information and referral are provided as appropriate.

MCH has four advisory committees: Perinatal Advisory Committee for the Perinatal Regionalization Program; Genetics Advisory Committee for the Newborn Metabolic Screening and the Newborn Hearing Screening Programs; the Children's Special Services Advisory Committee; and the Women's Health Advisory Committee.

Quality Management System: The quality units at the local level are empowered to resolve problems

whenever possible in addition to streamlining existing services. The State Quality Council meets twice yearly to review reports on QM activities, including aggregated trends and recommendations from quality units and quality teams. The Directors of MCH and Women's Health/Genetics serve on the State Quality Council. The statewide Quality Management Plan developed by the Bureau of Health Services is updated yearly. The quality management process, including record review and follow up, is conducted statewide to assure an optimum level of services for all clients. Clinic-specific patient satisfaction surveys, in English and Spanish, are conducted for one week of every year in all rural clinics.

Additional information related to II. E. State Agency Coordination:

Adolescent Health Program --

Youth health guides were purchased for Tennessee and are in the process of being distributed in partnership with the Departments of Education, Mental Health and Developmental Disabilities, Children's Services, and Human Services. The guides have been shared with faith groups, wellness teachers and school nurses as well as Department of Children's Services case managers. Adolescent health surveys from both public and private providers of adolescent health care have been completed and the data is being entered and analyzed. The results will be incorporated into the adoelscent health data report due Fall 2005. One public health nurse from each of the 13 regions throughout the state was identified as new contact persons with special interest and expertise in adolescent health care. In August 2004, the nurse representatives met to plan initiatives for the coming year. Throughout 2004-2005 the nurses provided regional adoelscent health training for their staff. They also shared tecnical assistance information with their regional contacts that was distributed by the director of adolescent health.

F. TECHNICAL ASSISTANCE

Tennessee is not requesting technical assistance at this time.

V. BUDGET NARRATIVE

A. EXPENDITURES

The MCH budget for the coming year remains basically the same as previous year submittals. The unobligated funds are reflected on Form 2. The required federal percentages for preventive and primary care for children (30%), children with special health care needs (30%) and administrative costs for Title V (10%) are met. Other sources of MCH funding include the required state match and other federal grants in support of MCH activity (Title X, Childhood Lead Poisoning Prevention Grant, SSDI, Abstinence Education, Newborn Hearing Screening, Early Comprehensive Childhood Systems, and Child Health and Development Program).

Because of the unique rules established allowing states to spend Title V funds over 24 months even though they are allocated annually, Tennessee uses this revenue source as the last dollar spent to support services for women, infants and children. Funds are used to support central office, local health departments, including metropolitan health departments, and services offered through special agency contracts. The contracts are used to fill gaps in service or to provide unique services to specific populations. Examples of MCH contracts are genetics and newborn screening services, services for CSHCN, abstinence education, home visitation programs, and family planning.

Detailed budget documentation is maintained in the fiscal office for the Bureau of Health Services and available for review as needed.

The only significant variation in expenditures from the previous year is on Form 4. The methodology used to divide expenditures for FY 2004 on Form 4 by the requested categories was revised. The revised method was determined to be a more accurate representation of the expenditures for the various categories, and uses recent service data for the determination. The same methodology was used to prepare the projected budget for FY 2006.

The financial control of all Department of Health programs is the responsibility of the Bureau of Administrative Services, which has a computerized system for availability of funds, program expenditures, and revenues collected.

Detailed Bureau of Health Services policies and procedures have been established for local health departments, regional offices, and the central office for all staff who are involved in management of funds and the process of contracting for services. These policies and procedures are available at all sites and are posted on the Bureau of Health Services' Intranet for easy reference by staff in all rural health departments and rural regional offices. These include procedures on who handles money, collecting fees, depositing fees, accounts receivables, aging of accounts, charging patients, private insurance and other third party funding sources, petty cash, posting receipts, etc. All policies and procedures have been developed in accordance with state law and procedures of the Department of Finance and Administration.

Computer printouts are generated for all MCH programs on expenditures and revenues, comparison to budgeted amounts and year-to-date activity. These are available on-line to the central office staff and regional office staff in the rural regions for tracking and monitoring expenditures and revenues by type. Financial audits are the overall responsibility of the Office of the Comptroller of the Treasury, which is responsible for audits in all state departments and all matters related to audits. Contracting agencies are subject to audit on a regular basis. Program staff perform routine site visits to contracting agencies for monitoring compliance with the contract's scope of services. The Department's Internal Audit staff are responsible for fiscal monitoring of the contracting agencies.

Metropolitan health departments operate within metro governments and have similar policies in place.

B. BUDGET

State law requires that all departments present a complete financial plan for the ensuing fiscal year that outlines all proposed expenditures for the administration, operation and maintenance of all programs. Procedures for completing the budget request are developed annually by the Department of Finance and Administration. The Bureau's Fiscal Services Section, with input from the program areas, is responsible for completion of the budget documents. After being approved by the State Legislature, an operational budget work plan is developed for each program for the year.

Under the system of resource allocation (described below) for both rural and metropolitan health departments, MCH dollars are used to budget for ongoing services and to fill gaps in annual fluctuations and unanticipated needs. The result is variation in amount of Title V carryover from year to year. An example of variation of carryover is the receipt of specialized grants by MCH and other sections that reduce the amount needed from the MCH Block Grant to support services during the time period of the grant. Other variations occur due to the large number of positions funded with MCH dollars at all levels of the public health system and the potential for wide variations in the number of vacancies during the year, recruiting efforts, and problems filling positions timely.

The Department of Health uses a cost allocation system for local health departments. Costs are allocated to programs in the rural health departments using two specific methods of charging costs: (1) Direct Cost Allocation method and (2) Resource Based Relative Value Scale Method (RBRVS). The direct cost allocation method is used when cost categories can be directly allocated to one or more programs. Salaries and benefits can be directly allocated via coding into the Labor Distribution System. Other costs such as travel, supplies, printing, contracts and equipment can be directly charged to programs via various accounting documents used by the state. This direct cost allocation method is reserved for costs that arise from administrative support staff in the Bureau of Health Services' central and regional offices and for contractual costs with metropolitan governments. The RBRVS method is the principal method of cost allocation used to spread to all programs in local health departments those costs which cannot be directly allocated to one or more programs. RBRVS adds up all weighted encounter activities using Relative Value Units (RVU) and allocates costs based on percent of activity for each program cost center. The Department of Health and Human Services, our cognizant agency, has approved RBRVS as an activity based cost allocation method for the Tennessee Department of Health. RBRVS is fully automated with computer linkages at the service delivery level to AS400 computers at the regional and central offices. Program encounter data are entered for local health department services using CPT procedure codes and program codes. Relative Value Units assigned to each procedure code allows a proportionate amount of cost to be associated with each procedure. Metropolitan health departments also use the PTBMIS data system to document services provided by staff. The State has contracts with the metropolitan health departments to provide MCH and other services. In state fiscal year 2003-4, approximately 3.7 million dollars were available from MCH Block Grant to support services for women and children in metropolitan areas.

The state established a Maintenance of Effort (MOE) state appropriation baseline in 1989 in accordance with the requirements of the Block Grant. The Fiscal Services Section of the Bureau of Health Services developed a formula for establishing the MOE based on state expenditure data for the 15-month period from July 1, 1988, through September 30, 1989, to bring expenditures current to the end of federal FY 1989. Then, state expenditures for July 1, 1988, through September 30, 1989, were totaled and subtracted from the 15-month expenditure amount, resulting in a 12-month total for the Federal FY of October 1, 1988 - September 30, 1989.

Accrued liabilities for the state fiscal year ending June 30, 1989, were determined and subtracted from the 12-month Federal FY total. Accrued liabilities are those costs that could not be liquidated at the close of the fiscal year but represent a liability to the state for the fiscal year in which they occurred. Accrued liabilities for October 1, 1988/June 30, 1989 and July 1, 1988/September 30, 1989 were determined. Since these accrued liability liquidations are actual expenditures in the fiscal year, they were added to the funding total. Unliquidated accrued liability savings were determined from the

1988 established accrued liabilities and adjusted as expenditures. These computations resulted in the establishment of the MOE of $13,125,024.28 in state funds for MCH.

MCH and other Department of Health programs achieve matching state dollar requirements through the state appropriation to the Department, earned income from services and in-kind match for special contracts for services to women and children. One strategy MCH implemented is aggressive reimbursement from MCOs for prior authorized services, especially for CSHCN. These are tracked through regional and central office fiscal management.

For the last few years, the unobligated balance carried forward by MCH has been significant. Reasons for this variation have been explained in the previous paragraphs. The carryover funds allow us to develop new services or initiate services that could be revenue producing in the future. During the past two years several major activities have been addressed using the MCH carryover funds. MCH partnered with several other departmental programs to expand and improve dental services and other health screening services. MCH helps to provide preventive fluoride varnish on the teeth of children seen in the health department clinics and mobile vans. In addition, MCH funds have been used to help fund the infant mortality, teen pregnancy prevention, and prenatal care components of the Better Health: It's About Time! initiative. The home visiting services for pregnant women and families with high risk infants and young children continued to be expanded, as was care coordination services for families with children with special health care needs.

For the first two years of the current administration, the Governor spent considerable time developing a budget for State Government which was within available resources. The budget for maternal and child health services for FY 2005-2006 remains basically the same as previous years. Unobligated funds are reflected on Form 2. The required federal percentages for preventive and primary care services for children (30%), children with special health care needs (30%), and administrative costs (10%) are met. Other sources of MCH funding include the required state match and other federal grants in support of MCH activity that are under the direction of the MCH and Women's Health directors. These include grants for lead poisoning prevention, family planning, health consultants in child care centers, abstinence, SSDI, and newborn hearing screening. Services, activities, and programs funded with the MCH Block Grant dollars are described within this document and represent all components of the MCH pyramid and include all target populations. Expanding MCH services for FY 2006 include implementation of new EPSDT outreach plans under contract with TennCare and implementation of the Early Comprehensive Childhood Systems grant.

VI. REPORTING FORMS-GENERAL INFORMATION

Please refer to Forms 2-21, completed by the state as part of its online application.

VII. PERFORMANCE AND OUTCOME MEASURE DETAIL SHEETS

For the National Performance Measures, detail sheets are provided as a part of the Guidance. States create one detail sheet for each state performance measure; to view these detail sheets please refer to Form 16 in the Forms section of the online application.

VIII. GLOSSARY

A standard glossary is provided as a part of the Guidance; if the state has also provided a state-specific glossary, it will appear as an attachment to this section.

IX. TECHNICAL NOTE

Please refer to Section IX of the Guidance.

X. APPENDICES AND STATE SUPPORTING DOCUMENTS

A. NEEDS ASSESSMENT

Please refer to Section II attachments, if provided.

B. ALL REPORTING FORMS

Please refer to Forms 2-21 completed as part of the online application.

C. ORGANIZATIONAL CHARTS AND ALL OTHER STATE SUPPORTING DOCUMENTS

Please refer to Section III, C "Organizational Structure".

D. ANNUAL REPORT DATA

This requirement is fulfilled by the completion of the online narrative and forms; please refer to those sections.